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ABSTRACT

This document is part of a series of monographs on community-based services for children and adolescents who are severely emotionally disturbed. The series is the product of a national study of community-based service approaches which identified over 200 programs serving emotionally disturbed children and included visits to several programs representing a variety of service delivery approaches. This volume begins with presentation of a model system of care, along with principles for service delivery. A literature- and program-based review of therapeutic foster care services is then presented, focusing on: definition and terminology; history; philosophy and goals; characteristics; variables such as treatment intensity and treatment approach; specific services such as preplacement, intervention, discharge, and follow-up; services to natural families; linkages; clients; staffing; treatment parents; resources; evaluation; and major advantages and challenges. Two programs are described in detail--the Family Network Program of the Lee Mental Health Center (Fort Myers, Florida) and Pressley Ridge Youth Development Extension (Pittsburgh, Pennsylvania.) One-page profiles of 32 therapeutic foster care programs are also provided. An appendix contains "The Story of Amanda," a case study of a 10-year-old emotionally disturbed child successfully treated in a therapeutic foster care home. (JDD)

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Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed

VOLUME III: THERAPEUTIC FOSTER CARE

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CASSP Technical Assistance Center
Georgetown University Child Development Center
Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

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SERIES ON COMMUNITY-BASED SERVICES FOR CHILDREN & ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED:

VOLUME III: THERAPEUTIC FOSTER CARE

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Middlebury, VT

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Lee Mental Health Center
Fort Myers, FL

Homebuilders
Behavioral Sciences Institute
Federal Way, WA

Huckleberry House
Columbus, OH

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PREFACE

The system of care for severely emotionally disturbed children and adolescents has been of great interest over the last several years. The conceptualization of this system has been a major focus in the advancement of the availability and appropriateness of services for this underserved population. In 1982, Jane Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances in this country, two million were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. Knitzer documented that only 21 states had a child and adolescent administrative unit within their departments of mental health and asserted that this dearth of leadership, lack of appropriate child mental health services, and fragmentation of systems has resulted in literally millions of children with serious emotional problems "falling through the cracks."

In 1986, Leonard Saxe performed a study for the Office of Technology Assessment (OTA) of the United States Congress, which confirmed Knitzer's findings. Saxe introduced this report, Children's Mental Health: Problems and Services, to Congress with the statement: "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available." Saxe presented three major conclusions:

- Many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively.
- A substantial theoretical and research base suggests that, in general, mental health interventions for children are helpful.
- Although there seem to be shortages in all forms of children's mental health care, there are particular shortages of community-based services, case management, and coordination across child service systems.

Even before the OTA study, Congress responded to these problems and to growing calls for change from the field, by funding, in 1984, an initiative to demonstrate the development of better functioning service systems. This effort led the National Institute of Mental Health to develop the Child and Adolescent Service System Program (CASSP). CASSP now supports 48 states in the development of interagency efforts to improve the systems under which the most troubled children and youth receive services. Through state and community level grants, the agencies that serve these youngsters -- mental health, health, social welfare, juvenile justice and special education -- are brought together to develop system change processes.

As states began struggling with system change, a number of critical questions evolved:

- What should a service system for children with serious emotional problems encompass?
- Toward what new configuration or ideal should service system change be directed?
- What are the components of the system?
- What is the ultimate goal of such systems change?

To provide a conceptual framework for the field and to answer these questions, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children and

Youth by Beth Stroul and Robert Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field.

Stroul and Friedman described the various service options required by these youths and the need for continuums of care across all of the relevant child-serving agencies. From these components, they proposed a design for a greater "System of Care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery.

The System of Care monograph describes a continuum of mental health services for severely emotionally disturbed children and adolescents. This continuum includes a group of important nonresidential service options that have been under-represented in states and communities. In order to assist states and communities that wish to develop a full system of care, CASSP initiated a major study on family-centered and community-based services for children and adolescents with serious emotional disturbance, which has resulted in this series of monographs.

This new series, which includes four volumes focusing on home-based services, crisis services, therapeutic foster care, and systems of care, complements the System of Care monograph as well as an earlier CASSP publication, Profiles of Residential and Day Treatment. Beth Stroul and Sybil Goldman have performed an extraordinary task in reviewing information on hundreds of community-based programs, in synthesizing this information, and in analyzing current treatment practices and service delivery strategies utilized within each of the three service modalities mentioned above. They have produced a truly "state-of-the-art" series on home-based services, crisis services, and therapeutic foster care. In addition, they have described in clear and direct prose three actual communities that have attempted to design and implement well-functioning systems of care for children with serious emotional problems and their families. This series constitutes a major contribution to the field and should be of great interest to program administrators at both the state and community levels, to service providers, to parents, and to advocates -- to all those interested in improving or developing community-based service options for these children and youth.

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INTRODUCTION

This document is part of a series of monographs on community-based services for children and adolescents who are severely emotionally disturbed published by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. This series is the product of an extensive national study of community-based service approaches for this population and includes the following volumes:

Volume I: Home-Based Services
Volume II: Crisis Services
Volume III: Therapeutic Foster Care
Volume IV: Systems of Care

There is broad agreement that comprehensive, community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal. Many communities offer the more traditional components of the system of care, such as outpatient, inpatient, and residential treatment services. However, there are a growing number of promising and innovative treatment approaches emerging in the field, and there is a tremendous need for information about these service alternatives. The study of community-based services, funded by the National Institute of Mental Health Child and Adolescent Service System Program, was designed to identify and describe three types of services -- home-based services, crisis services, and therapeutic foster care.

The study was conducted from 1986 to 1988 and initially involved a survey of over 650 organizations and individuals requesting that they identify programs providing home-based services, crisis services, and therapeutic foster care to a population of severely emotionally disturbed children. The initial survey resulted in the identification of approximately 200 programs across the nation. An extensive questionnaire then was sent to all identified programs in order to gather detailed information about their organization, philosophy, services, client population, staffing patterns, costs, sources of financing, evaluation results, problems encountered, and other aspects of their programs. Responses were received from more than 80 programs in 36 states, and a one-page profile summarizing major characteristics was prepared for each respondent program.

With the assistance of an advisory committee, several programs in each category were selected for in-depth study through site visits. The programs were selected with the goal of maximizing variation along key dimensions, including different service approaches and treatment philosophies, geographic regions, types of communities, and age groups or minority populations served. Additionally, an attempt was made to select programs that exemplify the core values and guiding principles for the system of care described in Chapter I of this document. The programs selected for site visits were not necessarily considered "model" programs. Rather, they were selected to serve as examples of a variety of service delivery approaches. There are, of course, a great many other programs in the field which are also extremely effective in providing these types of services to troubled children and their families.

In addition to site visits to programs in each of the service categories, the advisory committee recommended visiting three communities that appeared to have a wide array of service components in place as well as effective mechanisms for linking and integrating these services into a coordinated system of care. Three-day site visits were conducted in order to become immersed in the programs in an attempt to determine what makes them successful. The site visits involved observation of program activities and extensive meetings and discussions with program administrators, staff at all levels, staff from other community agencies, parents, foster parents, and children.

The analysis phase of the project involved synthesizing the information obtained from the survey, site visits, and literature review in each of the service categories. This monograph series represents the major study product, each volume providing a descriptive overview of the service approach, case studies of the programs visited, and profiles of the programs responding to the survey. The monographs are designed to provide information that will be helpful to state and community agencies, advocates, and others who are interested in developing these types of programs.

I. A SYSTEM OF CARE FOR CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED

In her book Unclaimed Children, Knitzer (1982) reported that two-thirds of all children and youth who are severely emotionally disturbed do not receive the services they need. Many others receive inappropriate, often excessively restrictive, care. Recently, there has been increasing activity to improve services for children and adolescents who are severely emotionally disturbed. In 1984, with funding appropriated by Congress, the National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) to assist states and communities to develop comprehensive, community-based systems of care for emotionally disturbed youth and their families. Coalitions of policymakers, providers, parents, and advocates currently are being forged across the nation to promote the development of such systems.

This chapter presents a model system of care along with principles for service delivery. The model and principles were developed through a project sponsored by CASSP with broad input from the field (Stroul & Friedman, 1986). The model offers a conceptual framework to provide direction to policymakers, planners, and providers. Individual service components, such as those described in this series, should be considered in the context of the overall system of care.

BACKGROUND

Two decades ago, the Joint Commission on the Mental Health of Children (1969) found that millions of children and youth were not receiving needed mental health services and that many others received unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of children and youth who are severely emotionally disturbed. Knitzer (1982) asserted that the needs of severely emotionally disturbed children have remained largely unaddressed. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them. Most recently, the Office of Technology Assessment (OTA) of the United States Congress (1986) found that many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively. The OTA report stated that it is a tragedy that "we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

These reports and others have made it apparent that the range of mental health and other services needed by children and adolescents who are severely emotionally disturbed is frequently unavailable. Many children are institutionalized when less restrictive, community-based services would be more effective. Additionally, there have been few attempts to get mental health, child welfare, juvenile justice, health, and education agencies to work together on behalf of disturbed children and youth. This has left children and youth who have serious and complex problems to receive services in an uncoordinated and piecemeal fashion, if at all.

Currently, there is broad agreement about the critical need to improve the range, appropriateness, and coordination of services delivered to severely emotionally disturbed children and their families. The development of comprehensive, coordinated, family-centered, and community-based "systems of care" for children and youth has become a national goal.

The term "continuum of care" has been used extensively in the field to describe the range of services needed by children and adolescents who are severely emotionally disturbed. Throughout this document, the term "system of care" is employed. "Continuum of care" generally denotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. "System of care" has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures, or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components **and** provisions for service coordination and integration.

A system of care, therefore, is defined as follows:

> **A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families.**

This chapter describes how these systems of care might look and the values and philosophy that should guide service delivery.

PRINCIPLES FOR THE SYSTEM OF CARE

The system of care concept represents more than a network of service components. Rather, it represents a **philosophy** about the way in which services should be delivered to children and their families. The actual components and organizational configuration of the system of care may differ from state to state and from community to community. Despite such differences, all systems of care should be guided by a set of basic values and operational philosophies.

There is general agreement in the field as to the values and philosophy which should be embodied in a system of care for youth who are severely emotionally disturbed. With extensive consultation from the field, two core values and a set of ten principles have been developed to provide a philosophical framework for the system of care model.

The two core values are central to the system of care and its operation. The first value is that the system of care must be driven by the needs of the child and his or her family. In short, the system of care must be **child-centered**, with the needs of the child and family dictating the types and mix of services provided. This child-centered focus is seen as a commitment to adapt services to the child and family rather than expecting the child and family to conform to pre-existing service configurations. It is also seen as a commitment to provide services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

Implicit in this value is that the system of care is also **family-focused**. In most cases, parents are the primary care givers for children with severe emotional disturbances, but efforts to work with and support families are frequently lacking. Parents often feel blamed, isolated, frustrated, disenfranchised, and shuffled from agency to agency, provider to provider. The system should be committed to supporting parents as care givers through services, support, education, respite, and more. There should also be a strong commitment to maintaining the integrity of the family whenever possible. Recent experience has confirmed that intensive services provided to the child and family can minimize the need for residential treatment, and that residential placements of all types are overutilized (Behar, 1984; Friedman & Street, 1985; Knitzer, 1982; Stroul & Friedman, 1986; United States Congress, 1986).

The second core value holds that the system of care for emotionally disturbed children should be **community-based**. Historically, services for this population have been limited to state hospitals, training schools, and other restrictive institutional facilities. There has been increasing interest and progress in serving such children in community-based programs which provide less restrictive, more normative environments. The system of care should embrace the philosophy of a community-based, family-centered network of services for emotionally disturbed youth. While "institutional" care may be indicated for certain children at various times, in many cases appropriate services can be provided in other, less restrictive settings within or close to the child's home community.

In addition to these two fundamental values for the system of care, ten principles have been identified which enunciate other basic beliefs about the optimal nature of the system of care. The values and principles are displayed on the following page.

SYSTEM OF CARE FRAMEWORK AND COMPONENTS

The system of care model presented in this chapter represents one approach to a system of care. No single approach as yet has been adequately implemented and tested to be considered the ideal model. The model presented is designed to be a guide and is based on the best available empirical data and clinical experience to date. It is offered as a starting point for states and communities as they seek to build their systems, as a baseline from which changes can be made as additional research, experience, and innovation dictate.

The system of care model is organized in a framework consisting of seven major dimensions of service, each dimension representing an area of need for children and their families. The framework is presented graphically on page 5 and includes the following dimensions:

1. Mental health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Operational services

The system of care model is intended to be **function-specific** rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. The model is **not** intended to specify which type of agency should fulfill any of the particular functions or needs. Certainly, particular agencies typically provide certain of these services. Educational services, for example, are provided most often by school systems, and social services generally are associated with child welfare or social welfare agencies. One might assume that the mental health services should be provided by mental health agencies. This, however, is often not the case.

All of the functions included in the system of care dimensions may be fulfilled by a variety of agencies or practitioners in both the public and private sectors. Therapeutic group care, a component in the mental health dimension, often is fulfilled by juvenile justice agencies and social service agencies as well as by mental health agencies. Day treatment is another mental health function that is frequently fulfilled by educational agencies, ideally in close collaboration with mental health providers.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

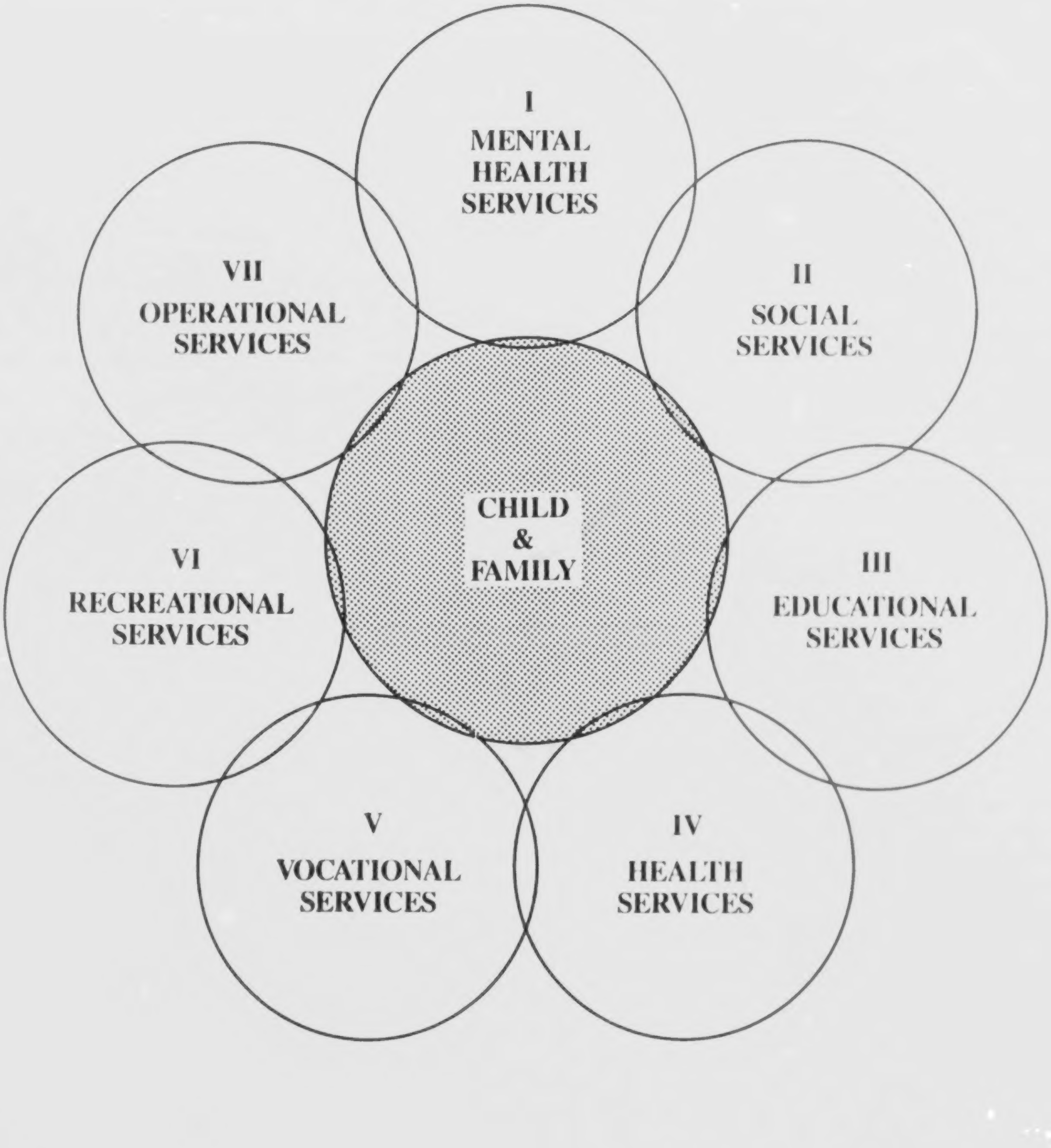
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

SYSTEM OF CARE FRAMEWORK



While the roles and responsibilities of specific agencies are acknowledged, many of the services can be, and are, provided by different agencies in different communities. Furthermore, many of these services are provided not through the efforts of any single agency but through multi-agency collaborative efforts. Such collaborations are important not only in identifying needs and planning services but also in developing, funding, and operating services. It should also be recognized that services are not always provided by agencies. Some functions within the system of care may be fulfilled by families, parent cooperatives, or other arrangements. In addition to public sector agencies and staff, private sector facilities and practitioners can play a pivotal role in the system of care, providing a wide range of services within each of the major dimensions. Additionally, juvenile justice agencies play an important role in the system of care by providing a wide range of services to children and adolescents who have broken the law (Shore, 1985).

An important aspect of the concept of a system of care is the notion that all components of the system are interrelated and that the effectiveness of any one component is related to the availability and effectiveness of all other components. For example, the same day treatment service may be more effective if embedded in a system that also includes good outpatient, crisis, and residential treatment than if placed in a system where the other services are lacking. Similarly, such a program will be more effective if social, health, and vocational services are also available in the community than if they are absent or of low quality. In a system of care, all of the components are interdependent -- not only the components within a service dimension such as mental health, but all of the seven service dimensions that comprise the model.

Within each of the seven service dimensions is a continuum of service components. These dimensions and the components within them are displayed on the following page. Of primary importance is the dimension of mental health services since these are critical services for all children who are severely emotionally disturbed. These services are divided into seven nonresidential categories and seven residential categories. When considering the individual services, it should be recalled that these are component parts of an overall system of care. The boundaries between the various dimensions and components are not always clear, and frequently there is overlap among them. While they are listed individually, the system of care dimensions and service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

A critical characteristic of an effective system is an appropriate balance between the components, particularly between the more restrictive and less restrictive services. If such balance is not present, then youngsters and families will not have a chance to receive less restrictive services before moving to more restrictive services. If, for example, within a community there are no intensive home-based services, only 20 day treatment slots and 50 residential treatment slots, the system is not in balance. Most likely, youngsters and families will have no opportunity to participate in home-based or day treatment services because they are relatively unavailable, and the residential components of the system will be overloaded with youngsters, some of whom might have been diverted from residential treatment if there had been more nonresidential services available.

At the present time there are no clear, empirically-based guidelines about the appropriate capacity within each component of a system of care. Implicit within a model system of service, however, is the expectation that more youngsters will require the less restrictive services than the more restrictive ones, and that service capacity, therefore, should diminish as one proceeds through the system. As additional research and field experience are accumulated on systems of care for severely emotionally disturbed children, it may become

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

Nonresidential Services:

- Prevention
- Early Identification & Intervention
- Assessment
- Outpatient Treatment
- Home-Based Services
- Day Treatment
- Emergency Services

Residential Services:

- Therapeutic Foster Care
- Therapeutic Group Care
- Therapeutic Camp Services
- Independent Living Services
- Residential Treatment Services
- Crisis Residential Services
- Inpatient Hospitalization

2. SOCIAL SERVICES

- Protective Services
- Financial Assistance
- Home Aid Services
- Respite Care
- Shelter Services
- Foster Care
- Adoption

3. EDUCATIONAL SERVICES

- Assessment & Planning
- Resource Rooms
- Self-Contained Special Education
- Special Schools
- Home-Bound Instruction
- Residential Schools
- Alternative Programs

4. HEALTH SERVICES

- Health Education & Prevention
- Screening & Assessment
- Primary Care
- Acute Care
- Long-Term Care

5. VOCATIONAL SERVICES

- Career Education
- Vocational Assessment
- Job Survival Skills Training
- Vocational Skills Training
- Work Experiences
- Job Finding, Placement & Retention Services
- Supported Employment

6. RECREATIONAL SERVICES

- Relationships with Significant Others
- After School Programs
- Summer Camps
- Special Recreational Projects

7. OPERATIONAL SERVICES

- Case Management
- Self-Help & Support Groups
- Advocacy
- Transportation
- Legal Services
- Volunteer Programs

possible to define the optimal ratios of capacities in the different system components (Friedman, 1987).

The operational services dimension is somewhat different from the other system of care dimensions. This dimension includes a range of support services that can make the difference between an effective and an ineffective system of care but do not fall into a specific category. Instead, they cross the boundaries between different types of services. They are called "operational services" because of their importance to the overall effective operation of the system. The services included in this dimension are case management, self-help and support groups, advocacy, transportation, legal services, and volunteer programs.

Case management is a service within this dimension that can play a critical role in the system of care. Behar (1985) calls case management "perhaps the most essential unifying factor in service delivery." The important role that case management can play in a system of service has been increasingly recognized in recent years but has been operationalized in only a few states.

Case management can be provided to youngsters in both residential and nonresidential programs. It involves brokering services for individual youngsters, advocating on their behalf, insuring that an adequate treatment plan is developed and implemented, reviewing client progress, and coordinating services. Case management involves aggressive outreach to the child and family, and working with them and with numerous community agencies and resources to ensure that all needed services and supports are in place. One important trend in serving emotionally disturbed children is to combine specialized case management with the availability of flexible funds to secure the specific mix of services and supports needed by each individual child and family on a case-by-case basis (Update, 1986).

Advocacy can also play a critical role in the system of care. "Case" advocacy, or advocacy on behalf of the needs of individual children, is needed as well as "class" advocacy, or advocacy on behalf of a group of children. Class advocacy, if successful, can have a greater impact than case advocacy because it can produce changes that affect more children (Knitzer, 1984). Efforts to advocate for improved services are beginning to take the form of coalitions of parent, provider, professional, and voluntary advocacy organizations. These coalitions are forming at community, state, and national levels and are beginning to provide a much needed voice in support of system of care development.

The increased interest in advocacy is one of the more encouraging signs in the children's mental health field in recent years. A key issue affecting the degree to which effective systems of care will be developed is the extent to which strong, persistent, and well-targeted advocacy efforts can be developed.

SERVICE DEVELOPMENT

The model described in this chapter can be used as a guide in planning and policy-making and provides a framework for assessing present services and planning improvements. It can be conceptualized as a blueprint for a system of care which establishes directions and goals. States and communities should revise and adapt the model to conform with their needs, environments, and service systems. The model also must be regarded as flexible, with room for additions and revisions as experience and changing circumstances dictate.

Most important is the acknowledgment that conceptualizing a system of care represents only a **preliminary step** in the service system improvement process. Development of a system of care model is a planning task which must be followed by implementation activities. While designing a system of care is an essential and challenging task, the real challenge for states and communities is to transform their system of care plans into reality.

Using the framework that the mental health dimension of this model provides, it is apparent that many communities are able to provide the more traditional services to emotionally disturbed children and their families, services such as outpatient services, inpatient services, and services in residential treatment centers. The service gaps generally include some of the more innovative service approaches such as home-based services, intensive day treatment, therapeutic foster care, crisis services, case management, and support services such as respite care.

Because these types of services frequently are lacking in communities, the study of community-based service approaches was initiated by the CASSP Technical Assistance Center at Georgetown University. The intent of the project was to develop and disseminate detailed information about specific service delivery approaches in order to assist states and communities in their efforts to implement similar programs. Thus, this series is designed to provide the tools for policymakers, planners, providers, parents, and advocates to translate their system of care plans into reality.

The three service components selected for study and described in the series are home-based services, crisis services, and therapeutic foster care. Home-based services are counseling, support, and case management services provided on an outreach basis to work intensively with severely emotionally disturbed children and their families in their homes. Many home-based service programs are crisis-oriented, intervening during crisis situations in which the child is in imminent danger of placement in an out-of-home setting. These programs work intensively with families on a relatively short-term basis with the goal of stabilizing the child and family and connecting them with ongoing services as needed. Other programs have developed longer term home-based interventions to work more extensively with families. Some of these programs are based on the assumption that families can benefit from a long and stable association with a professional. Some of the major characteristics of home-based services include the following:

- o The intervention is delivered primarily in the family's home.
- o The intervention is multifaceted and includes counseling, skill training, and helping the family to obtain and coordinate necessary services, resources, and supports.
- o Staff have small caseloads to permit them to work actively and intensively with each family.
- o The programs are committed to empowering families, instilling hope in families, allowing families to set their own goals and priorities and assisting them to achieve these.

Crisis services for children and adolescents involve numerous types of agencies, services, settings, and personnel that respond to crisis situations. The range of services includes crisis telephone lines, often specialized for particular types of problems such as suicide or substance abuse; walk-in and outpatient crisis intervention services; mobile crisis outreach services including home-based services and emergency medical teams; and crisis residential services including runaway shelters, crisis group homes, therapeutic foster homes used for short-term crisis placements, and crisis stabilization units. Inpatient hospitalization services of various types are seen as back-up to these other types of crisis services, to be used when other approaches are not adequate for responding to particular situations.

The underlying goals of virtually all of the crisis programs identified in the study were to assist children and adolescents and their families to resolve crises and to avert hospitalization. Despite diverse approaches and settings, there are many similarities among crisis programs for children with emotional disturbances:

- They intervene immediately.
- They provide brief and intensive treatment.
- They focus treatment on problem solving and goal setting.
- They involve families in treatment.
- They link clients and families with other community services and supports.

Because crisis services provide brief, intense interventions, they generally are followed by other services. Thus, it is critical for crisis programs to maintain strong and effective linkages with all other components within the overall system of care.

Therapeutic foster care is considered the least restrictive, most normalizing of the residential options within the system of care. There is much controversy over what therapeutic foster care should be called -- foster family-based treatment, special foster care, individualized residential treatment, and other labels. The primary concern is differentiating therapeutic foster care, which is a form of **treatment** for troubled children, from regular foster care. Therapeutic foster home programs report that they successfully serve some of the most severely disturbed youngsters in home settings, some youngsters that could not be managed in the most restrictive, highly supervised institutional settings.

Therapeutic foster care usually involves:

- Recruitment of treatment parents specifically to work with emotionally disturbed children. Treatment parents are seen as the primary therapeutic agents.
- Provision of specialized training to the treatment parents to assist them in working with emotionally disturbed children and creation of a support system among the treatment parents.
- Payment of a special stipend to the treatment parents significantly higher than the rate of payment for regular foster care.
- Staff who work closely with each child and treatment family and usually assume both clinical and case management roles.
- Counseling, support, and other forms of assistance to biological families.

Therapeutic foster care programs can be flexible and can easily individualize the treatment approach and program for each child. They can serve both sexes, children of different ages, and children with a wide variety of problems. Some therapeutic foster care programs offer more intensive versions for children with the most severe problems. These involve hiring a human service professional to serve as the treatment parent and provide full-time, one-on-one care for a severely disturbed child or utilizing rotating shifts of foster parent assistants to provide intensive, continuous care and supervision in the context of the therapeutic foster home.

While each volume of the series describes a particular service component, the interdependence of all system components should be kept in the forefront. No one service or program can meet the complex needs of emotionally disturbed children and their families. Thus, it may not be wise to devote all available resources to developing one or two services without considering the entire system. Each of the services described in this series must be part of a comprehensive, coordinated system of care which is dedicated to meeting the multiple and changing needs of severely emotionally disturbed youngsters and their families. Volume IV of this series describes the efforts of several communities to link a variety of service components into well coordinated systems of care.

REFERENCES

Behar, L.B. (1984). An integrated system of services for seriously disturbed children. Paper presented at the ADAMHA/OJJDP "State of the Art Research Conference on Juvenile Offenders with Serious Alcohol, Drug Abuse, and Mental Health Problems," Rockville, MD.

Behar, L.B. (1985). Changing patterns of state responsibility: A case study of North Carolina. Journal of Clinical Child Psychology, 14, 188-195.

Friedman, R.M. (1987). Service capacity in a balanced system of services for seriously emotionally disturbed children. Unpublished manuscript. University of South Florida, Florida Mental Health Institute, Tampa.

Friedman, R.M., & Street, S. (1985). Admission and discharge criteria for children's mental health services: A review of the issues and options. Journal of Clinical Child Psychology, 14, 229-235.

Joint Commission on the Mental Health of Children. (1969). Crisis in child mental health. New York: Harper & Row.

Knitzer, J. (1982). Unclaimed children. Washington, DC: Children's Defense Fund.

Knitzer, J. (1984). Developing systems of care for disturbed children: The role of advocacy. Rochester, NY: Institute for Child and Youth Policy Studies.

President's Commission on Mental Health. (1978). Report of the sub-task panel on infants, children and adolescents. Washington, DC: U.S. Government Printing Office.

Shore, M. (1985). Mental health and the juvenile justice system: A mental health perspective. Paper presented at the NASMHPD/NIMH Symposium "Addressing the Mental Health Needs of the Juvenile Justice Population: Policies and Programs," Washington, DC.

Stroul, B. & Friedman, R.M. (1986). A system of care for severely emotionally disturbed children and youth. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

United States Congress, Office of Technology Assessment. (1986). Children's mental health: problems and services - A background paper. Washington, DC: U.S. Government Printing Office.

Update. (1986). Case management. Update, Newsletter of the Research & Training Center for Children's Mental Health, 2, 10-12, 15. Tampa, FL: Florida Mental Health Institute.

II. THERAPEUTIC FOSTER CARE

DEFINITION AND TERMINOLOGY

Therapeutic foster care is considered the least restrictive option among the range of residential services for severely emotionally disturbed children and adolescents. Therapeutic foster care can be defined as a service which provides treatment for troubled children within the private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home.

Therapeutic foster care is seen as a relatively new form of care and treatment that is struggling to establish a clear-cut identity (Meadowcroft, 1988; Webb, 1988). The recent proliferation of therapeutic foster care programs with a wide variety of characteristics and labels has made it difficult to reach agreement on a definition. While there may not as yet be agreement on a precise definition for this approach, there is a universal emphasis on distinguishing therapeutic foster care from traditional or regular foster care. The primary function of regular foster care is to provide a substitute family environment for dependent children, whereas the primary function of therapeutic foster care is to provide a treatment environment for troubled children.

Barnes (1980) noted that because of the basic similarity to traditional foster care, therapeutic foster care may mistakenly be viewed as a "variation on a theme." However, the distinctions between the two are substantial and pertain to at least four dimensions: the types of persons recruited as parents, the payments they receive, the preparation required for the parenting role, and the assistance received in performing the parenting role (Cox & Cox, 1989). First, regular foster parents generally are recruited and selected based upon their willingness and ability to provide nurturant, custodial care. Foster parents for therapeutic foster care programs (often referred to as "treatment parents") are selected based upon their skills and motivation to handle the challenges posed by severely disturbed children. The payments to treatment parents are significantly higher than payments to traditional foster parents to compensate for the enormous skill, effort, and difficulties involved in working with children with emotional problems and in acknowledgment of the professional nature of treatment parenting.

Extensive preservice and inservice training are provided to treatment parents. This training, which far exceeds the training provided to regular foster parents, is designed to provide treatment parents with the coping skills and intervention techniques needed to implement treatment programs for the children in their care. Finally, treatment parents are provided with extensive professional assistance and supervision, a marked contrast from the sporadic visits of caseworkers to regular foster homes. A professional staff person is in frequent contact with the treatment family, providing technical advice, support, encouragement, and crisis assistance for the treatment parents and the child.

These differences underscore the basic premise that therapeutic foster care is designed to conduct therapeutic intervention programs with clearly stated treatment goals within the home environment of the foster family, and not simply to provide substitute care and nurturance (Bryant & Snodgrass, 1989; Snodgrass & Campbell, 1981). Regardless of the similarity in setting, it is the "treatment" aspect of therapeutic foster care that is its most important distinguishing characteristic.

The fledgling association of therapeutic foster care providers (initially called the Treatment Foster Care Association [TFCA] and currently called the Foster Family-based Treatment

Association [FFTA]) attempted to define therapeutic foster care and identify its broad parameters (TFCA Newsletter, 1988). The service was defined as "a program of foster family-based treatment for special needs individuals." The critical elements of this definition were further specified:

- Special needs individuals - The individuals served by therapeutic foster care programs are in need of **both** out-of-home placement and specialized treatment related to their special needs and are at risk for more restrictive placements.
- Treatment - The treatment provided in therapeutic foster care includes services and procedures designed to produce a planned outcome in a person's behavior, attitude, or general condition. The provision of treatment presumes that there are stated goals, procedures for achieving goals, and assessment of results; the foster family is the recognized locus of treatment.
- Foster family-based - Therapeutic foster care uses legally constituted and duly approved foster family homes which provide quality family care, nurturance, and supervision and, with appropriate training and support, are further expected to function as the principal agents of treatment.

This preliminary definition was proposed to the field through the newsletter with a request for feedback and was debated at the Second North American Conference on Treatment Foster Care held in 1988. In a subsequent newsletter, the Foster Family-based Treatment Association defined therapeutic foster care as "a dynamic family and community-based program for children whose needs require intensive care and treatment outside their homes. It provides comprehensive, individualized services implemented by a team of professionals and trained foster families. Treatment foster care enables children to live successfully in family and community settings" (Focus FFTA, 1989).

Further evidence of the struggle to define therapeutic foster care can be seen in the array of terms that currently are used to describe this approach, such as:

Special foster care
Specialized foster care
Enriched foster care
Intensive foster care
Foster family-based treatment
Treatment foster care
Treatment family care
Therapeutic family care
Individualized residential treatment
Professional foster care
Professional treatment homes
Professional parenting
Family treatment homes

There has been considerable discussion, and some controversy, regarding the most appropriate "generic" term to describe therapeutic foster care (Hawkins, 1987; Hawkins & Luster, 1982; Webb, 1988). Concern about terminology is closely related to the concern about distinguishing therapeutic foster care from regular foster care. Hawkins (1987) asserted that the last word in a label tends to identify the primary concept that the label conveys. Thus, terms ending with the words "foster care" may convey that "foster care" is the fundamental thing done. However, the primary purpose of most programs is treatment rather than foster care per se, and, for this reason, Hawkins expressed a preference for the term "foster family-based treatment."

Others concur that terminology should be used carefully to avoid the connotation of regular foster care. There is a particular need to distinguish therapeutic foster care from regular foster care in the minds of policymakers and legislators who must pay substantially more for treatment services in foster home settings than for the largely custodial foster care services with which they are more familiar. While some programs do not use the words "foster care" in their labels, others cite powerful arguments for retaining this terminology. For example, Snodgrass (1988) noted that failure to define the service as foster care might ultimately jeopardize the tax exempt status of payments to treatment parents.

The terms "therapeutic foster care" and "foster family-based treatment" seem to be emerging as generally accepted generic descriptors of this treatment approach. It seems clear that regardless of their titles and the terminology used, therapeutic foster care programs share their focus on exceptional children and their emphasis on applying planned treatment and treatment technologies within the family environment found in a foster home. The generic term "therapeutic foster care" is used throughout this document.

HISTORY

Bryant (1980a; 1981) observed that therapeutic foster care is a growing treatment resource for intensely disturbed and handicapped children. The growth of therapeutic foster care reflects a movement away from treating disturbed children in institutional settings and towards providing community-based and family-based services. Bryant noted that foster family homes have been considered the preferred care setting for "normal," dependent children since the turn of the century, with institutions evolving as specialized treatment settings to serve disturbed and handicapped youngsters. The deinstitutionalization movement and related trends, however, have created a demand for community-based services for troubled youngsters. The therapeutic foster care model has begun to fill this service vacuum by combining the family and community-based aspects of the foster home with the structure and treatment functions of the institution.

Historically, families have not been seen as appropriate settings for children with serious mental health needs. Historic biases against treating disturbed children in family settings were cited by Meadowcroft and Luster (1989); a 1965 study emphatically concluded that the idea of replicating a family situation to care for disturbed children should not be perpetuated and that institutions should be the major focus of care (DeFries, Jenkins, & Williams, 1965). Over the past two decades, however, a number of forces have coalesced, and therapeutic foster care is increasingly perceived as an effective resource for serving exceptional children. These trends include developments in child welfare, mental retardation, mental health, and education systems, all of which favor the use of the least restrictive, community-based, family-oriented service alternatives (Bryant, 1980a; 1981).

In the child welfare system, for example, family foster care was developed as a more appropriate and humane alternative to child care institutions and shelters. Recent philosophical and legal trends recognize the importance of preserving the natural family and mandate that services be provided to maintain family integrity wherever possible. When out-of-home placement is unavoidable, a foster family environment is considered the best substitute for the natural family. The principles of normalization and community integration have gained prominence in the field of mental retardation. Rather than providing care and treatment in institutions, a variety of community-based services and settings have been developed for mentally handicapped individuals. Similarly, the mental health field has moved away from institutional care for both children and adults and has embraced the goal of creating systems of community services in order to support persons in normal community life. Efforts to improve mental health services to children have focused on the over-reliance on excessively restrictive treatment environments and the need for comprehensive systems of care which provide a range of less restrictive, more normalized nonresidential and residential services (Knitzer, 1982; Stroul & Friedman, 1986).

Trends in education also have supported the use of more normalized, community-based service approaches. Public Law 94-142, the Education for All Handicapped Act, requires that special education be provided to handicapped youngsters in the least restrictive environment appropriate to their needs. Additionally, court decisions have spurred the development of community and family-based services. A 1974 case, W. Gary versus the Louisiana Department of Health and Human Resources, considered the rights of Louisiana children in out-of-state placements. The court found that children have a right to treatment and placements near to their own homes and which impose the least of all possible restrictions on their freedom. The decision required the creation of a range of community-based alternatives for disturbed and handicapped youngsters, among them a therapeutic foster care program. Thus, the deinstitutionalization movement and related trends across service systems created philosophical, political, legal, and legislative pressure to adhere to the principle of "least restrictive setting" in making placement and treatment decisions.

These trends have been fueled by increasing recognition of some of the problems associated with institutional care, particularly for children and adolescents. While highly specialized care and treatment may be provided in institutional settings, Bryant (1980a; 1981) cited several serious problems:

o There is an inherent distrust and dislike of the large and impersonal nature of institutions.

o Institutions are seen as socially depriving, failing to provide adequate learning or coping situations for children, and producing the "hospitalism" or apathy which is characteristic of institutional patients.

o By virtue of serving groups of youngsters, institutions allow extensive peer influence, modeling, and peer reinforcement of normally unacceptable social behavior, which may ultimately decrease the likelihood of successful functioning in normal community life.

o Many youngsters are unable to generalize desirable behavior learned in institutional settings to more normal, but very different, community environments.

These problems and others have led to increasing support for the use of family environments for placement and treatment. The issue of generalization of therapeutic progress is of critical importance. Proponents of family-based services argue that generalization of therapeutic gains is enhanced when treatment occurs in a setting that closely approximates the setting to which the child must adjust permanently. Most children in treatment settings eventually will return to their natural families, foster homes, or adoptive homes. Thus, treatment provided in a family environment is more likely to help them to adjust successfully in the long run than treatment carried out in more artificial, congregate environments (Bryant, 1980a; Bryant & Snodgrass, 1989). Therapeutic foster care offers advantages in this regard by combining the structure and treatment technologies of treatment-centered institutions with the normalizing influence of family and community life. The concept of adapting a foster family to create a treatment system which closely approximates true community living has been referred to as creating an "institution without walls" (Rubenstein, Armentrout, Levin, & Herald, 1978).

Some programs trace their beginnings to the realization that many youngsters fare better in family settings. People Places in Staunton, Virginia, initially was designed to provide weekend placements for youngsters in a state-run residential treatment facility. When it was observed that many youngsters seemed to do better in the foster homes than in the residential treatment center, the program was extended to offer full-time placements in treatment homes (Bryant, 1983). The East Arkansas Regional Mental Health Center in Helena, Arkansas, found that children made better progress when treated in stable, natural family settings as compared with a group home. As a result, the agency converted its group residential treatment program into a therapeutic foster care program.

Another impetus for the experimentation with alternative approaches has been the rapidly escalating costs of residential treatment centers, group homes, psychiatric hospitals, and the like (Bauer & Heinke, 1976). Early therapeutic foster care programs clearly demonstrated their cost-effectiveness. Bryant (1980a; 1981) reported that several early programs provided therapeutic foster care to intensely disturbed children who would otherwise have been institutionalized at one-half to two-thirds the cost of institutional care. In view of the limited resources available for mental health services, there is an increasingly urgent need to explore effective but less costly treatment options. The relative economy of therapeutic foster care as compared with institutional treatment has made it an attractive addition to a system of care.

The evolution of therapeutic foster care programs can be seen in two distinct phases (Bryant & Snodgrass, 1989; Webb, 1988). The first programs emerged in the 1950s and 1960s, primarily as experimental or pilot efforts. Many of these programs were short-lived, perhaps because the "conventional wisdom" at that time did not perceive the foster home as an appropriate treatment environment for disturbed children (Bryant & Snodgrass, 1989). During this early phase of development, many programs were initiated by institutions to serve a transitional or aftercare function for children who were ready for discharge from the residential facility but were not yet ready to (or could not) return to their families. They were considered **supplements** to residential treatment facilities.

These early therapeutic foster homes were not appreciably different from regular foster homes; the major difference was that they served a significantly more disturbed population of youngsters. While foster parents were provided with intensified supports to manage these challenging youngsters, the responsibility for treatment and therapy rested with mental health professionals, outside of the home context. These programs have been described as an intensification of the traditional foster care model, a difference in degree from regular foster care rather than a difference in kind (Snodgrass & Bryant, 1984). Examples of early attempts at providing therapeutic foster care include programs initiated in 1951 by the Baltimore Family and Children's Society (Gray, 1957; Waskowitz, 1954), in 1952 by the Illinois Children's Home and Aid Society (Wildy, 1962), and in 1963 by Family and Child Services in Washington, D.C. (Fine, 1966). As noted, many programs were developed by residential treatment centers to fulfill a transitional aftercare function, such as the Astor Home Program in New York (Mora, 1962), the Ypsilanti Program in Michigan (Rice and Semmelroth, 1968), and the Merrifield Program in Massachusetts (Bryant, 1980a; 1981).

During the second phase of evolution, beginning in the late 1960s and continuing to the present, therapeutic foster care developed increasingly as **alternatives** to more restrictive forms of residential treatment rather than as transitional supplements. Additionally, programs began to develop some of the special characteristics which now define therapeutic foster care. Most important was the shift in the primary locus of treatment to the treatment home rather than the therapist's office and the accompanying shift in the role of the foster parents from nurturant caregivers to primary treatment agents (Bryant & Snodgrass, 1989; Snodgrass & Bryant, 1984; Welkowitz, 1987). The qualitative changes in the later programs include an explicit focus on achieving planned therapeutic changes; a professionalizing of the role of the foster parents with appropriate training and payment; and a new consultive, supervisory, and supportive role for staff. The newer programs represent a significant departure from regular foster care in their clear treatment orientation. The shift is evident in the tendency among programs to replace the term "foster parent" with terms such as "teaching parent," "treatment parent," "professional parent," "parent counselor," "parent therapist," and the like. Examples of second phase programs include the Treatment Family Care Homes Program established in

Wisconsin in 1968 (Bauer & Heinke, 1976), the Alberta Parent Counselors Program established in 1974 in Calgary and Edmunton, Canada (Larson, Allison, & Johnston, 1978), the Parent-Therapist Program initiated in Ontario, Canada in 1972 (Rubenstein, Armentrout, Levin, & Herald, 1978), the Treatment Alternatives Project developed in Boston (Bedford & Hybertson, 1975), and People Places which was started in Virginia in 1973 (Bryant, 1980a; 1981).

Throughout the 1980s therapeutic foster care programs have been proliferating throughout the United States, Canada, and Europe, and most of these programs are conceived of as full-scale alternatives to more restrictive forms of residential treatment. To provide a cross-cultural perspective, Hazel (1982) reported that while some countries still believe in treating youth in large institutions, other nations, such as Sweden, trust lay people working in their own homes to undertake even the most difficult tasks and have reduced the number of children in residential treatment facilities to a very small number. The approach is seen as providing promise for the future due to its unique potential to effectively treat severely disturbed youngsters in minimally restrictive settings which offer the advantages of normal family life. Bryant and Snodgrass (1989) predict that therapeutic foster care as a program type will continue to grow in the years ahead as the preferred placement alternative for many disturbed children and youth.

PHILOSOPHY AND GOALS

Therapeutic foster care programs are based upon the fundamental belief in the value and importance of family-based care. The belief that a family setting represents the best possible treatment environment is the major philosophical underpinning of the approach. This philosophy rests upon several key assumptions (Bryant, 1980a; 1981). First, most children eventually will enter or return to some type of family situation. Social learning theory suggests that the treatment of psychological disturbances should take place in a setting which most closely approximates that to which the individual must adjust permanently. Treatment within the context of a family setting will help children to adjust successfully to a family setting in the future. Since changes made during residential treatment often do not generalize to the child's home situation, the therapeutic foster care approach maximizes the likelihood of generalization of therapeutic gains (Webb, 1988). Further, a healthy family setting is seen as a potential training ground for basic parenting and relationship skills. The treatment family offers highly functioning role models of acceptable behavior which may help to counter the family pathology and disorganization experienced by some youngsters (Hawkins & Luster, 1982).

Implicit in this belief in family-based care is the belief that the first and greatest investment should be made in the care and treatment of children and families in their own homes. Most programs specify that the decision to utilize out-of-home care should be made only after great consideration (Stroul, 1988). However, therapeutic foster care programs subscribe to the notion that when separation from the natural family is unavoidable, the treatment setting that is most likely to promote the child's adaptive adjustment is another family (Bryant, 1980a; 1981; 1983). While separation from the natural family may have deleterious effects, some of these may be mitigated by placing the child in a loving, stimulating, personalized environment (Webb, 1988). Given society's belief that family life is the best environment for a child, therapeutic foster care programs assert that emotionally disturbed children should not be denied the experience of family and community life by virtue of their specialized treatment needs.

Along with the philosophy of family-based care, therapeutic foster care programs subscribe to the principle of providing treatment in the least restrictive, most normalized environment. Therapeutic foster care provides the closest possible approximation of a normal environment that can be achieved in an out-of-home placement. Children live in families, can attend community schools, and can be involved in community activities and utilize community resources. Additionally, the home settings are minimally restrictive, placing the fewest possible limits on the child's activities, social contacts, and physical environment and placing the most normal daily responsibilities and expectations on the child (Hawkins, 1989).

The tendency to confuse the concepts of restrictiveness and treatment intensity is receiving considerable attention (Burge, Fabry, & James, 1987; Friedman, 1989; Hawkins, Almeida, Meadowcroft, Fabry, & Luster, 1988; Hawkins & Luster, 1982). While treatment intensity and restrictiveness may go together, this is not necessarily the case. Children may spend more actual hours in a hospital or residential treatment center than in other treatment settings, but treatment intensity depends upon how much of this time is used for active treatment activities. As noted by Burge, Fabry, and James (1987), bricks, mortar, and fences do not define the setting where intensive treatment can take place; highly intensive and individualized treatment programs can be provided in minimally restrictive family-based settings. Hawkins and Luster (1982) define treatment intensity as depending upon such factors as the amount of time spent engaged in activities intended to produce change; the degree of individualization of the assessment and treatment plan; and the amount of stimulus support provided to produce appropriate behavior. They define restrictiveness as the degree to which available activities deviate from the norm for persons of comparable age and development; the degree to which rules limit involvement in normal activities; the similarity of the types and frequency of social contacts to the norm; and the similarity of the physical environment to that encountered by others. Based on these definitions, it is apparent that therapeutic foster care offers the least restrictive, most normalized of the residential treatment alternatives. This does not mean, however, that this form of care is less treatment intensive or less capable of serving children with severe problems. On the contrary, programs indicate that they provide highly intensive and individualized treatment to severely disturbed children in minimally restrictive environments.

The specific treatment philosophies espoused by therapeutic foster care programs represents one of the major differences among them. Webb (1988) observed the diversity in treatment philosophy, noting that most programs are at least partially behaviorally oriented, though some emphasize a psychodynamic approach and others build their therapy around a family systems orientation. Welkowitz (1987) identified three major elements of the treatment philosophy of therapeutic foster care programs, each emphasized to different degrees by individual programs:

- **Behavioral/Learning-Based Approaches** - Many programs take a learning-based approach to client treatment (Bryant & Snodgrass, 1989). This approach has its roots in documented success in training biological parents to be effective therapeutic agents as well as in the success of the Teaching Family Model of group home treatment. Using a behavioral approach, it has been demonstrated that parents can be trained to be effective change agents and can successfully treat their child's behavioral problems in the home (Hawkins, Peterson, Schweid, & Bijou, 1966; Penn, 1978). Similarly, the Teaching Family Model involves training "teaching parents" to be the primary treatment agents who implement treatment procedures for small groups of youngsters in home-like settings within the community. The Teaching Family Model, first implemented in 1967 at Achievement Place in Kansas, has provided a wealth of experience regarding how carefully planned methods of behavioral intervention can be applied successfully by married couples trained as therapeutic agents, within the context of community-based, home-like settings (Jones, Weinrott, & Howard, 1981; Kirigin, Braukmann, Atwater, & Wolf, 1982).

  It followed that if parents could serve as effective treatment agents using learning-based methods, and if group home parents could improve the behavior of several troubled adolescents in their care, then foster parents could also be trained to conduct treatment effectively for one or two children in their homes (Hawkins, Meadowcroft, Trout, & Luster, 1985). Thus, the philosophy, language, and methods of behavioral and learning-based treatment approaches have been incorporated extensively into therapeutic foster care programs. Bryant and Snodgrass (1989) stated that the behavioral treatment technology is particularly well suited for therapeutic foster care as it is "so logical, straightforward, and compatible with good, typical parenting practices that it can be reasonably taught to and implemented by foster parents with hope of beneficial results." In addition, the approach offers concrete programs aimed at specific behaviors, is easily communicated, and its effectiveness can be assessed easily (Penn, 1978). While programs generally do not rely exclusively on behavioral or learning-based methods, many have found this approach to be particularly well-suited to therapeutic foster care. Treatment parents learn to "re-educate" children on a daily basis, using teaching as a method to reduce and prevent problem behavior (Meadowcroft & Grealish, 1989).

- **Supportive Family Setting** - The second element of the treatment approach for therapeutic foster care programs involves the treatment environment itself. The family setting, in the larger context of the community, is seen as a vital part of the intervention. The child reaps the benefits of stable, nurturant care and close relationships with healthy parent figures. Children are further exposed to and participate in all of the activities of daily family and community living. The healthy family milieu is considered a critical ingredient in the therapeutic process (Welkowitz, 1987).

- **Family Systems Approach** - The third element of the treatment philosophy of many therapeutic foster care programs derives from family systems theory. The underlying assumption is that some disturbed children are part of a larger system, the family, which may be troubled. These programs attempt to intervene and achieve changes in the child's natural family, particularly in cases where reunification with the natural family is the desired outcome. Thus, in addition to providing a therapeutic environment for the child, efforts are focused on the child's family and community systems.

Despite differences in treatment philosophy and approach among programs, most therapeutic foster care programs strive to achieve two major goals:

- To provide a family-based treatment alternative to institutions and to minimize the need for more restrictive residential placements.

- To facilitate the child's positive emotional and behavioral adjustment and to strengthen the child's ability to function effectively in the community.

The first goal, shared by the majority of therapeutic foster care programs, is to provide a less restrictive, family-based treatment alternative. Minimizing the need for institutional care by providing a family alternative was identified as a major purpose by more than two-thirds of the therapeutic foster care programs responding to a survey (Snodgrass & Bryant, 1989).

A second and complementary goal of therapeutic foster care programs focuses on improving the child's adjustment in all spheres -- emotionally, behaviorally, socially, and educationally. This goal involves using therapeutic interventions to change the maladaptive behaviors of troubled children and to help them to develop more adaptive behaviors. Programs may approach this challenge differently depending upon their treatment philosophies, but all programs seek to achieve and document therapeutic gains as a result of their intervention. The desired outcome of improving the child's functioning is to enable him or her to move to the least restrictive environment possible for long-term care. Although long-term placement decisions are made on an individual case basis, most programs strive to return children to their natural families where feasible or to prepare children for adoption, long-term foster care, or, in some cases, independent living.

An additional goal is subscribed to by fewer programs, approximately 22 percent of the programs responding to the Snodgrass and Bryant (1989) survey. This goal involves helping children to readjust to family and community living upon discharge from residential treatment facilities. This transitional function, common to many of the early therapeutic foster care programs, remains an active purpose for some therapeutic foster care programs operating today. For example, the Professional Parent Homes operated by the Northeastern Family Institute (NFI) in Burlington, Vermont, are used as longer-term therapeutic placements after youngsters have completed the NFI residential program.

A final goal of some therapeutic foster care programs is to provide long-term placements for troubled children who have little likelihood of returning home. Programs, such as People Places, allow youngsters to remain in treatment homes on a long-term basis if it is not feasible for them to return home. In some situations, moving the child to another environment would create a risk of failure, and there is justification for maintaining the child in the treatment home over time. Once the pathology has been improved, the focus of the treatment parents shifts to goal setting, achieving stability, and teaching the skills needed for independent living. Thus, therapeutic foster care services can be used for time-limited treatment as an alternative to more restrictive residential care, as a transition back to the community following discharge from residential treatment, and as a long-term placement option for disturbed children who cannot return home.

CHARACTERISTICS

Therapeutic foster care programs can be developed and administered by a variety of organizations and agencies, most commonly private, nonprofit human service agencies, public departments of social services, and public departments of mental health. The majority of programs included in the recent survey conducted by Snodgrass and Bryant (1989) were operated by voluntary, nonprofit agencies (75 percent); only 25 percent of the respondent programs were characterized as public agencies. Similarly, this current survey found that over 80 percent of the responding programs were private, nonprofit agencies; 16 percent were public agencies, and one program was operated by a private, for-profit organization (.03 percent).

The dominance of private agencies in providing therapeutic foster care has been attributed to a number of formidable obstacles faced by public sector agencies in attempting to develop and operate such programs. For example, public agencies may have difficulty achieving the small caseloads needed to ensure effective and intensive supervision and support for treatment parents (Snodgrass & Bryant, 1989). Particularly in social service agencies, workloads have increased exponentially in attempting to cope with rising demands for investigations, protective services, and family-based services related to child abuse and neglect. These agencies, often understaffed to begin with, may not be able to allocate sufficient staff time to a therapeutic foster care program. When public agencies do attempt to create a therapeutic foster care unit, turf problems may result between regular foster care and therapeutic foster care staff as a result of competition for scarce foster homes or resentment of the significantly smaller caseloads assigned to the therapeutic foster care staff (Bryant, Simmons, & McKee, 1987). Because of these and other bureaucratic obstacles, public agencies often elect to contract with private providers for therapeutic foster care services. There are examples of successful therapeutic foster care programs under public agency auspices, such as the Allegheny County (Pennsylvania) Specialized Foster Home Program (Carros, & Krikston, 1989) and programs throughout Missouri (Bryant, Simmons, & McKee, 1987). Snodgrass & Bryant (1989) predict an expansion of public sector programming in the future, contingent upon the ability of public agencies to limit caseloads.

Until recently, the majority of therapeutic foster care programs were operated by social service agencies. There is evidence that mental health systems increasingly are becoming involved in therapeutic foster care. Public departments of mental health and community mental health centers are launching therapeutic foster care programs, often in collaboration with social service agencies. For example, the Allegheny County Specialized Foster Home Program is jointly funded by the child and youth services agency and the mental health/mental retardation agency. Additionally, some programs are developed and operated by residential treatment centers or state psychiatric hospitals and some are university-affiliated.

Despite differences in organizational context, therapeutic foster care programs share a number of distinctive features. The major characteristics of therapeutic foster care have been described by Meadowcroft (1988), Meadowcroft and Luster (1989), Bryant (1980a; 1981), Webb (1988), and others. Based upon the literature and observations from the field, it appears that most therapeutic foster care programs have the following common features:

1. Therapeutic foster care provides a nurturant, family environment for one or two children with special needs.

Therapeutic foster care is provided in the private homes of substitute families. The placement of only one troubled child per treatment home is considered ideal, and most programs attempt to adhere to this guideline. The placement of only one child in a treatment home enables the treatment parents to provide the highly intensive and individualized care needed to work with youngsters who are severely disturbed. Additionally, limiting the number of children in a single treatment home curtails the potential negative influences of other troubled peers (Meadowcroft & Luster, 1989). Under some circumstances, two youngsters might be placed in a treatment home. This may occur with sibling groups, when one youngster in placement demonstrates consistent progress and stability and the treatment parents appear capable of working with an additional child, or when it may be therapeutically advantageous for the child to be placed with another child of particular characteristics.

In rare situations, therapeutic foster care programs place more than two youngsters in a treatment home. The Therapeutic Foster Homes Program operated by Kaleidoscope in Chicago has one treatment home with four children. Both treatment parents consider this their full-time employment, and a full-time child care worker was hired to assist the treatment parents and provide relief. This is the exception, however, and most programs limit their treatment homes to one, or occasionally two, youngsters in order to preserve the individualized attention of family living.

2. Therapeutic foster care programs regard treatment parents as professional staff who are the primary agents of treatment for the child.

Therapeutic foster care programs "professionalize" the role of treatment parents, considering them and treating them as professional staff. The professional status of treatment parents is a critical component of therapeutic foster care and is reflected in every aspect of the program's relationship with its treatment parents (Bauer & Heinke, 1976; Bryant, 1980a, 1981; Meadowcroft & Luster, 1989; Webb, 1988). Parents are recruited and selected based upon their skills and motivation to serve children with severe problems and are provided with specialized training to prepare them for their role. They assume primary responsibility for directly implementing treatment plans and procedures for the child in addition to providing basic care and a therapeutic milieu. They are seen as co-professionals on the treatment team, and as such are active participants in the process of selecting children for their home, preplacement planning, designing treatment plans and goals, and assessing progress.

The payment of treatment parents also reflects their status as professional staff. Treatment parents are reimbursed at a rate significantly higher than that of regular foster parents in recognition of the high levels of skills and commitment demanded by the job. Many programs offer treatment parents salaries and benefits consistent with other agency employees. Treatment parents are expected to demonstrate competence in their work; their performance is evaluated regularly; and they generally are provided with ongoing training opportunities to enhance their skills. In addition, they are accorded respect by the program staff, are treated as colleagues, and are accepted and valued as having legitimate ideas and abilities.

3. Program staff provide frequent consultation, supervision, and support to treatment parents.

The role of program staff in therapeutic foster care differs significantly from many other mental health programs. Rather than providing direct treatment services per se, the primary role of staff can best be characterized as a consultant or supervisor to the treatment parents. Staff supervise, advise, support, train, and monitor treatment parents, assisting them to carry out their role as treatment agents. Staff are in frequent contact with treatment parents, usually visiting treatment homes weekly or biweekly. Visits may be even more frequent during the initial phases of a placement or during crises, and telephone consultation may occur as often as daily, if needed. The telephone contacts and home meetings are used for various purposes including reviewing events, conducting in-home training of treatment parents, designing new treatment strategies, providing support and encouragement, and meeting with the child if necessary (Meadowcroft & Luster, 1989). Meadowcroft (1988) emphasized that the main responsibility of staff is to support treatment parents so that they can provide high quality care and to ensure that treatment parents do not become overly stressed.

4. Program staff have low caseloads to permit them to work actively and intensively with each treatment family, child, and natural family.

The role and responsibilities of program staff require extensive involvement with each treatment family. In addition to supervising and supporting the direct therapeutic efforts of the treatment parents, staff often are responsible for working with the child's natural family, working with the child when necessary, and coordinating all community resources and services needed by the child. In some programs, staff also are responsible for providing follow-up services to the child following discharge from the treatment home. These activities are time consuming, and staff of therapeutic foster care programs have caseloads which are sufficiently low to allow for this active and intensive involvement. In their survey, Snodgrass and Bryant (1989) found that the average maximum caseload among all respondent programs was 15. However, for the 10 programs serving more severely disturbed clients, the average caseload maximum was 12.5. Meadowcroft and Luster (1989) reported that most staff of therapeutic foster care programs carry caseloads of no more than 12 to 15 children; the most typical caseload is approximately 10, although some programs have caseloads as low as 5 to 7.

5. Therapeutic foster care provides treatment services in the context of the treatment home.

The primary function of therapeutic foster care is to provide **treatment**. As noted, it is this feature which distinguishes therapeutic foster care from regular foster care. As opposed to simply assuring nurturing care, therapeutic foster care programs are oriented toward producing adaptive developmental changes in children (Bryant, 1980a; 1981). Treatment methods vary widely across programs due to differences in treatment philosophy. However, Bryant (1980a; 1981) observed that regardless of differences in orientation, the treatment in most therapeutic foster care programs is highly goal-directed.

In addition to variations across programs, treatment services often vary within programs based upon the individual needs of each child (Meadowcroft, 1988). By definition, treatment parents are considered to be the main treatment agents for the child, with primary responsibility for implementing those treatment activities and interventions which are expected to have a positive effect on the child's adjustment. Many programs employ treatment technologies based upon behavior analysis and teaching of appropriate behaviors, a technology which is easily learned and implemented by treatment parents in a home setting (Meadowcroft & Luster, 1989). The treatment approach of most programs involves an initial assessment of the child's needs, the development of a goal-oriented treatment plan, daily tracking of progress on treatment goals, and periodic review and revision of the treatment plan depending upon progress.

The treatment provided by therapeutic foster care programs also may involve counseling by a professional therapist. As recognized by Meadowcroft and Luster (1989), the treatment parents may not be able to meet all of the child's treatment needs. Accordingly, some children may receive additional clinical services from an "outside" therapist who may or may not be employed by the agency providing the therapeutic foster care services. Meadowcroft and Luster warn, however, that the danger in using professional counselors involves potential undermining or usurping the role of the treatment parents as the main treatment agents. As a result, the goal for professional counseling often is to assess the child's situation and prescribe additional training or consultation for treatment parents or staff. Professional counselors may serve as clinical consultants to the treatment team in addition to providing direct treatment services to selected children.

6. Therapeutic foster care programs provide 24-hour crisis intervention services to treatment families and children.

By virtue of serving a population of severely disturbed youngsters, crisis situations are inevitable. Crises occur in the home, school, and community and include incidents of aggression, property damage, running away, antisocial behavior, suicidal behavior, drug abuse, and others. (Meadowcroft & Luster, 1989). An essential feature of therapeutic foster care programs is the capacity to respond to crisis situations on a 24-hour-a-day, 7-day-a-week basis. Most programs have an on-call system of some type, often with staff rotating responsibility for crisis response. Program staff, and in some cases a crisis intervention team, are available for telephone consultation and, when necessary, to go to the home, school, or wherever the crisis is occurring to assess the situation and take any necessary steps to intervene. The availability of program staff to respond to crises is one of the most important supports provided to treatment parents who are working with severely disturbed youngsters in their homes.

Most programs are equipped with back-up placement options for use in crisis situations in which it is necessary to remove the child from the treatment home. Intervention efforts generally are directed at preventing removal of the child from the treatment home, but some events may require removal for a cooling off period, for investigation of an event (such as an alleged incident of abuse against another child in the home), or for stabilization. Back-up placement options include other treatment homes, special treatment homes that are designed and staffed for children in crisis, crisis or diagnostic units operated by the program for short-term assessment and crisis intervention, or local psychiatric facilities (Meadowcroft & Luster, 1989; Meadowcroft, 1988). In most cases, the goal is to return the child to the treatment home following resolution of the crisis.

7. Therapeutic foster care programs carefully select treatment parents and provide them with extensive training.

Treatment parents are carefully selected by therapeutic foster care programs based upon their skills, personal qualities, and motivation to work with severely disturbed children. The selection process normally involves as series of applications, interviews, and home visits coupled with observation and performance assessment during the preservice training experience. The selection process is designed to identify candidates who can function best as professional members of a treatment team (Webb, 1988).

Extensive training is provided to treatment parents in order to prepare them to fulfill their role as primary treatment agents (Bryant, 1980a, 1981; Meadowcroft & Luster, 1989). Beyond the natural parenting abilities sought in treatment parents, special skills are needed to provide effective treatment for severely troubled children. In order to prepare treatment parents, programs provide intensive preservice training, often combining didactic methods with experiential approaches to ensure that treatment parents master the requisite skills.

In addition to preservice training, programs provide ongoing inservice training. Most inservice training is in the form of practical, individualized, on-the-job training. Much of the supervision provided by staff is actually training, helping the treatment parents to develop and refine the specific skills needed to work with the child in their home at the time. Programs also provide more formalized inservice training opportunities for groups of treatment parents as well as opportunities to participate in conferences and other related training events.

8. Therapeutic foster care programs provide a variety of forms of support to treatment parents.

Beyond training, a range of supports are provided to treatment parents in order to help them to fulfill their role and to avoid "burn-out." One of the most important supports is periodic respite care. Programs provide respite care in a variety of ways. Respite workers may be hired and trained to provide respite within the treatment homes. Alternatively, treatment parents may be recruited and trained to provide respite within their own homes. This approach may be particularly well suited to treatment parents who desire a break from full-time placements. Often, active treatment parents provide respite for each other based upon reciprocal arrangements (Meadowcroft, 1988).

In addition to respite, supports to treatment parents may include family counseling, 24-hour crisis intervention services, bonuses, opportunities for advancement within the agency, social events, and various types of recognition. (Meadowcroft & Luster, 1989). Further, many programs encourage the development of support networks among treatment parents which provide the opportunity to share successes and problems, to exchange ideas and techniques, and to provide mutual support and encouragement (Meadowcroft, 1988). This often is accomplished informally through monthly inservice training meetings and other events which allow treatment parents to form informal networks and relationships. Some programs build networks into their design, organizing "clusters" of five or six treatment families (Gedeon, 1986; Larson, Allison, & Johnston, 1978; Rubenstein, Armentrout, Levin, & Herald, 1978). The treatment families within a cluster function as extended family, sharing responsibility for all the children within the cluster and providing respite and a range of other supports for each other.

9. Therapeutic foster care programs involve natural parents in the child's treatment to the extent possible and appropriate.

The emphasis on the involvement of the natural parents varies widely across programs. Many programs attempt to keep natural parents actively involved in the child's placement and treatment. Involvement of the natural parents takes many forms, including regular visits between the child and natural parents in accordance with the treatment plan; participation with the treatment team in the development of the child's treatment and discharge plans and in the periodic assessment of progress; provision of direct services to assist natural parents in resolving any personal problems or issues; and assistance to prepare natural parents for the child's eventual return home and to assume the role of change agent for the child (Bryant, 1980a; 1981).

In most programs, the staff member assigned to the child also is responsible for working with the natural family. Both counseling and "casework" services may be provided to assist families to obtain those resources and services needed to function more effectively. Some programs arrange support groups for natural families whereby families can assist each other to deal with the painful effects of separation and with the anxieties and challenges of coping with an emotionally disturbed child. Further, some programs encourage the development of a supportive relationship between treatment parents and natural parents whereby treatment parents can provide consultation to natural parents and become an ongoing source of support in managing the child and promoting his or her healthy development. In cases where there is little likelihood of the child returning home or where parental rights have been terminated, some programs regard the involvement of natural families as inappropriate or not feasible. Others, however, strive to involve natural parents regardless of the long-term placement goal. Their rationale is that the primary goal should be to enhance the relationship between parents and child and that parental involvement is important to the child's progress. Programs report that finding effective ways of involving and working with natural families is one of the most challenging aspects of therapeutic foster care, requiring skill, creativity, commitment, and persistence.

10. Therapeutic foster care programs maintain active linkages with a variety of community agencies, particularly with school systems.

Therapeutic foster care programs are, to a great extent, dependent upon the quality of the relationships they develop and maintain with a wide variety of community agencies and resources. All needed adjunct services are, theoretically, available within an institutional setting. In a community treatment setting, however, program staff are responsible for accessing and coordinating all of the services and resources needed by the child, treatment family, and natural family. The range of services that may be needed include special educational services, vocational services, mental health services, health care services, substance abuse services, sexual abuse services, job training services, recreational services, and more. Program staff must have good working relationships with personnel in all of these areas in order to obtain and effectively coordinate service delivery (Meadowcroft & Luster, 1989).

Of critical importance is the quality of the program's relationships with local school systems. Meadowcroft and Luster (1989) emphasized that most children in therapeutic foster care have special educational needs and that therapeutic foster care can fail if a child fails within his or her school placement. Strong, effective educational liaison services are an essential aspect of therapeutic foster care to ensure that the child is in an appropriate educational placement and to advocate for the child within the school system as well as to assist school personnel in handling behavior management and academic problems. Therapeutic foster care programs generally spend a great deal of time and effort working with school personnel.

MAJOR VARIABLES - TREATMENT INTENSITY AND TREATMENT APPROACH

Therapeutic foster care programs may differ with respect to such features as organizational auspices, program size, population served, extent of involvement of natural parents in the treatment process, and the like. One significant variable concerns the uses of therapeutic foster care. As noted, some programs define themselves primarily as alternatives to more restrictive treatment environments, while others are used for transitional or aftercare supplements to residential treatment. Additionally, some programs consider it appropriate to use treatment homes as long-term placement options for youngsters who cannot return home. Long-term foster care within a treatment home or adoption are allowed and even encouraged under appropriate circumstances. Other programs regard their role more stringently as time-limited treatment and are reluctant to use their highly specialized treatment homes for long-term care.

Another variation in the use of therapeutic foster care involves programs specifically designed to provide crisis intervention services in the context of treatment homes. In these programs, treatment parents are selected and trained to provide short-term emergency placements and to assist youngsters and their families in crisis situations. The Little Brothers Emergency Shelter Network in Portland, Maine, is an example of a program in which treatment parents provide constant supervision and crisis intervention for youngsters for an average of two weeks. Outreach counselors work with children, their natural families, and the treatment parents to assess needs, provide crisis counseling, develop a short- and long-term service plan, access appropriate community resources, and provide ongoing counseling following discharge from the emergency therapeutic foster home. The Counseling Service of Addison County in Middlebury, Vermont, offers a similar service using therapeutic foster care environments for short-term, crisis intervention purposes. A spinoff of PRYDE, the PRESS program (Pressley Ridge Emergency Shelter Service), also provides short-term crisis services in therapeutic foster homes. (See Goldman, 1988 for more information on emergency therapeutic foster care and other types of crisis services).

Beyond these differences in uses, the major variables among therapeutic foster care programs appear to center around two dimensions which can be described as treatment intensity and treatment approach. In an attempt to characterize the variable of treatment intensity, Stroul and Friedman (1986) identified two broad categories of therapeutic foster care programs. The first category includes those programs which provide treatment parents with modest increases over regular foster care payments and offer some general training and frequent supervision. These programs rely primarily on the family environment as the primary therapeutic intervention, but children are likely to receive additional treatment services from mental health professionals. The second category includes programs which regard treatment parents more as employees and provide them with a more substantial salary. Treatment parents are required to complete a more technical training experience and are responsible for implementing a well-defined treatment plan for the child within their home. Clearly, the second category of programs can be described as more "treatment-intensive" or more "treatment-oriented."

Hawkins (1987) also attempted to capture and describe this variable among therapeutic foster care programs. He identified a continuum of therapeutic foster care program types or levels beyond regular foster care which essentially represents variations in treatment intensity. He identified 10 variables which can be used to define the "level" (i.e., treatment intensity) of a therapeutic foster care program, including:

- Parent qualifications
- Parent training by agency
- Support and supervision of parents by agency
- Intensity and generality of interventions directly with youth
- Intensity and generality of indirect interventions
- Case manager/staff qualifications
- Staff training by agency
- Support and supervision by staff
- Professional competencies of other staff
- Program accountability for process and outcome

According to this schema, the more rigorous and systematic a program is regarding each of these variables, the more treatment-intensive or treatment-oriented it can be considered. Thus, the more treatment-intensive programs would be expected to have more stringent qualifications for treatment parents, more extensive parent training programs, higher levels of staff supervision for treatment parents, and so forth. Of particular importance is the defining variable concerning the intensity of the interventions with the youth. This variable refers to the provision and documentation of intensive treatment procedures which are part of an individualized treatment plan. It implies the systematic use of some type of "treatment technology," regardless of the specific nature of that treatment technology.

Hawkins (1987) attempted to assign names to different "levels" of therapeutic foster care along this continuum and identified three levels of therapeutic foster care listed in order of increasing treatment intensity: special foster care, treatment foster care, and foster family-based treatment. Although the concept of a continuum of therapeutic foster care programs which vary along the dimension of treatment intensity is a useful one, care must be taken in applying these terms to differentiate among program types. While there may be different connotations associated with some of these terms, there is little consistency in their use by the various programs and individuals in the field. In many instances, the terms are used interchangeably regardless of the differences in program characteristics. Further, it would be exceedingly difficult at this stage of development of therapeutic foster care to define either qualitatively or quantitatively just "how much" of each of these defining variables would qualify a program for each label.

More recently, Hawkins (1989) described the dimension of treatment intensity as being comprised of the two sub-dimensions of potency and breadth. The "potency" of treatment refers to the power of an intervention to produce change in the specific behaviors targeted, as reflected by the speed and magnitude of such change. The "breadth" of treatment refers to the number of different situations in which the behavior is monitored and changed, the number of related behaviors that are changed, and the number of different persons in the child's environment whose behavior is changed. He noted that therapeutic foster care programs vary in both potency and breadth, affecting the more general dimension of treatment intensity. At this time, it is important to recognize that therapeutic foster care programs do vary along the dimension of treatment intensity, with some programs providing higher levels of active, systematic treatment interventions within the context of the treatment home than others.

In order to achieve even higher levels of treatment intensity within the context of a therapeutic foster home, some programs have developed special intensive versions to serve the most severely disturbed and difficult youngsters. For example, the West Virginia Youth Advocate Program offers the Special Residential Advocate Program which is designed to provide intensive behavioral stabilization services to particularly difficult youth with serious emotional problems. The Special Residential Advocate (SRA) is a full-time, salaried staff member of the agency who is responsible for the youth on a 24-hour-a-day basis within the treatment foster home. SRAs are required to have appropriate educational backgrounds and considerable experience in working with special needs youngsters; they are provided with extensive additional training. The Mentor Program, based in Boston, provides two full-time mentors (i.e., treatment parents) to work with one youth who is in need of constant supervision and treatment (Hensley, 1986).

The PRYDE Program in Pittsburgh has designed and implemented an intensive model in West Virginia. The approach involves creating highly intensive and individualized programs within the treatment home setting and drawing upon a wide array of program and community resources to provide technical consultation and support to the treatment parents. One case described by Burge, Fabry, & James (1987) involved a child with a history of unsuccessful placements (including a psychiatric hospital and a residential treatment center). The resources enlisted for his care and treatment included three parent assistants, PRYDE staff, a child psychologist, psychiatrist, child clinical consultant, special education teacher, and a host of other individuals and agencies. Similarly, the Lee Mental Health Center in Fort Myers, Florida, operates a more intensive version of its therapeutic foster care program, termed the Individual Residential Treatment Program. This program is designed to serve children with severe emotional disturbance who have been deemed to require restrictive, residential placements and who clearly require more care and treatment than the standard therapeutic foster home can provide. The Individual Residential Treatment Program involves hiring professional therapeutic parents, paid professional salaries, to provide full-time, one-on-one, 24-hour community support and treatment. Staff visit the home two to three times per week to provide consultation and support, and ancillary services are provided as appropriate.

The second major variable is the treatment philosophy and approach espoused by the therapeutic foster care program. As noted, many programs are committed to learning-based treatment technologies; others indicate a preference for interactional counseling strategies or other therapeutic approaches. The salient issue appears to be the degree of reliance on the overall therapeutic milieu of the treatment home versus the degree of reliance on highly structured, primarily behavioral, treatment approaches. By definition, all therapeutic foster care programs use the environment of a healthy, functioning family as a critical component of the intervention. The difference lies in the **relative emphasis** placed on the therapeutic value of the family environment and on the use of structured interventions (Welkowitz, 1987). Some programs employ highly structured, learning-based or behavioral treatment programs for all children in treatment homes; others emphasize the integration of the child into a healthy, supportive family and devote less attention to structured or behavioral treatment strategies. Yet other programs adjust the degree of treatment structure and the treatment approach to meet the needs of individual children.

PRYDE offers an example of a program with a highly structured, heavily behavioral treatment approach. Treatment parents implement well-defined motivation systems for each youngster and maintain extensive daily records to track progress on treatment goals. The Parent-Therapist Program of Youth Residential Services in Akron, Ohio, is a program which relies less on highly structured and behavioral treatment approaches and more on the overall therapeutic value of the treatment home. Parent therapists provide a warm and caring environment, serve as positive role models, help children to learn how to interact in normal ways, and implement the treatment plan. The Lee Mental Health Center also sees the therapeutic milieu as the major therapeutic agent, the catalyst that allows the child to change. The Professional Parenting Program of the Bringing It All Back Home Study Center in Morganton, North Carolina, incorporates features of both approaches, relying initially on the therapeutic value of the home and the skills of treatment parents but utilizing more structured, behavioral interventions when indicated (Update, 1986). Thus, the relative emphasis on the therapeutic home milieu, on the use of structured, behavioral techniques, and on the use of other treatment approaches represents a significant difference among therapeutic foster care programs.

SERVICES

Phase I: Preplacement

The vast majority of referrals to therapeutic foster care programs originate from social service or child welfare agencies (Friedman, 1981; Grealish & Meadowcroft, 1989). For the three programs described by Grealish and Meadowcroft, 87 to 100 percent of the referrals are from local or state child welfare agencies. The programs involved in this study indicated that social service agencies are the primary referral source for therapeutic foster care, with mental health agencies and hospitals or residential treatment centers representing the next most frequent referral sources. Juvenile justice agencies and school systems also refer youngsters for therapeutic foster care services; parents or relatives were cited by only two programs as a referral source.

Therapeutic foster care programs generally require that detailed referral information be provided in order to assist the program in determining if the child can be served in a therapeutic foster care setting (Barnes, 1980; Grealish & Meadowcroft, 1989). Referral information also is used to choose an appropriate family for the child and to begin the process of developing a treatment and educational plan. The information provided upon referral may include:

- Reason for referral
- Description of youth and presenting problem areas
- Legal status of youth
- Social history and description of prior placements
- Family history and relationship with family
- History of emotional problems and prior mental health treatment
- Results of psychological and psychiatric evaluations
- Medical history
- Educational history and school records

Some programs utilize "selection and review committees" that review referral information and determine a child's eligibility and appropriateness for therapeutic foster care. The interagency case review committee in each Florida district reviews all children who are purported to need therapeutic placements outside the home, including those referred for therapeutic foster care. Other programs use supervisory staff to make such judgments. In making their determinations, programs often are guided by a defined set of acceptance criteria. For example, programs may limit eligibility to children residing within a certain geographic area, to a certain age range, or to children exhibiting particular types of problems. Additionally, programs may consider certain behaviors unacceptable for therapeutic foster care services, such as a recent history of arson, violence, uncontrollable aggressive behavior, or sexual offenses which might constitute a potential danger to the family (Barnes, 1980; Grealish & Meadowcroft, 1989).

Once it is determined that a youngster is appropriate for therapeutic foster care, the process of "matching" begins -- selecting a treatment family with the best combination of characteristics and skills to assist the particular child. Matching is considered one of the most critical steps in providing therapeutic foster care in that the success of the intervention is largely dependent upon the appropriateness of the treatment family selected for each individual child. Snodgrass and Bryant (1989) emphasized that no amount of support from the agency can compensate for a poor match. A host of variables are considered in matching a child with a treatment family, including the parenting style of the treatment parents and their ability to manage the particular problem behaviors displayed by the child as well as treatment parents' ages, the ages and gender of other children in the household, socio-economic status, cultural/ethnic characteristics, educational levels, type and amount of religious involvement, lifestyle, and preferred leisure activities. Additional factors are taken into account in matching, such as the type of home and neighborhood, location in an urban or rural environment, proximity to the natural family, and, of course, the availability of an appropriate educational placement in the area (North Carolina Department of Human Resources, 1987). The preferences, both of the treatment family and the youngster, also play a crucial role.

In an attempt to discern the matching variables considered most significant by therapeutic foster care programs, Snodgrass and Bryant (1989) addressed this issue in their survey. Approximately three-quarters of the respondent programs indicated that the treatment family's preferences regarding age, sex, life circumstances, or type of problem of the youngster are significant in making placement decisions. Approximately half of the respondent programs attempt to match the child to a treatment family with proven skills for handling the types of problems demonstrated by the child. Snodgrass and Bryant observed that it is rare to find treatment parents who work well with most children; it is more common to find treatment parent who work well with certain types of children. Thus, family preferences and suitability of skills to the particular situation appear to be two of the most salient considerations in the matching decision.

Another important consideration is the composition of the treatment family, particularly with respect to other children in the household. Grealish and Meadowcroft (1989) noted that a youth with a history of abusing younger children would not be placed in a family with young children. The siblings in the treatment family and the potential effect of the placement on family functioning must be major considerations in determining an appropriate match (Hampson, 1988). Issues that are easily overlooked but can create stress in placement include such factors as treatment parents' tolerance of youngsters' smoking, use of birth control, prior or current sexual activity, and so forth.

The advisability of matching children with families of different socio-economic levels or different races has been debated among therapeutic foster care programs. Some programs report few difficulties involved in mixing economic or racial backgrounds; others recommend that children be placed with families of similar cultural, ethnic, and socio-economic backgrounds to the extent possible. Regarding interracial placements, Beggs (1987) quoted a treatment parent as recommending "in-race" placement with the rationale that troubled children have enough problems without having to cope with cultural differences (such as different foods) or being the only white child in a black neighborhood, or vice versa.

The matching process generally begins with a thorough review of all referral information and an interview or series of interviews with the youngster. The interview allows program staff to observe the youngster first-hand, to explain the nature and purposes of the program, and to obtain a sense of the youngster's preferences and attitudes towards therapeutic foster care. Once sufficient data on the child and his or her needs is obtained, the program proceeds to identify an available family with the appropriate mix of skills and lifestyle characteristics for the child. This identification of potentially appropriate treatment families may be accomplished subjectively by program staff or more systematically, aided by computerized data banks which compare information on referred children with available treatment parents. People Places has developed a standardized decision-making process using a series of weighted family variables considered most important to a successful match. The families with the highest rankings are identified through this data-based system as being good potential placement candidates for the particular child (Snodgrass & Campbell, 1981). To date, there has been no research comparing the success of data-based matches with the more subjective matches made by staff (Hampson, 1988).

When an appropriate treatment family is identified, the family is provided with information about the youngster and his or her problems in order to enable them to make an informed decision. A variety of steps are taken prior to the actual placement to enhance the likelihood of a successful match (Grealish & Meadowcroft, 1989). Videotapes of the child or observation through a one-way mirror allow treatment parents to gain a more accurate picture of the youngster. Using these techniques, treatment parents can decide against a placement early in the process without subjecting the child to a rejection experience. Preplacement or trial visits are used by the vast majority of programs to continue the decision-making process and to allow gradual introduction of the child into the family. An initial visit may take place at a restaurant or other neutral setting, followed by trial visits at the treatment home. These visits, which may be overnight or for a weekend, enable program staff to observe the child in the family setting and provide both the child and treatment parents the actual experience of the placement rather than a mere description. According to Grealish and Meadowcroft, programs typically require at least two preplacement visits, and either the child or the treatment family may end the preplacement process at any point if they have serious reservations or objections. Reportedly, only a very small percentage of potential matches do not work out due to the discomfort of treatment parents or children during the preplacement phase. If both parties agree, a date may then be established for the placement to begin.

It should be noted that some programs prefer to have treatment families meet the child **prior** to reading extensive background material. Written materials may show the child in the most negative light and may make problems appear overwhelming. The Lee Mental Health Center, while never withholding information from treatment parents, may have treatment parents meet the child before reading the entire case history. The entire preplacement process can take as little as two weeks to as much as several months depending upon the availability of a treatment home appropriate to the child's needs. Although programs may sometimes speed up the preplacement process, most are not "emergency" programs; they emphasize that carefully planned matching of the child and treatment home is an essential aspect of therapeutic foster care.

Grealish and Meadowcroft (1989) described two problems that commonly occur during the matching and preplacement process. First, youngsters may be resistant, threatened, or frightened, particularly since many of them have experienced difficulties within their own families or within previous placements. Strategies to decrease this resistance include developing an open and trusting relationship with the child during all preplacement contacts, allowing the child to participate actively and meaningfully in the placement decision, and helping the child to negotiate expectations and rules with the potential treatment family including chores, bedtimes, smoking, church attendance, and the like. Efforts to include and involve the youngster throughout the preplacement decision making process is especially important for adolescents. If the youngster is involved as an active participant and has some degree of control, he or she is more likely to develop an investment in making the placement and the treatment plan successful (Barnes, 1980).

Further, natural parents may be resistant to their child's placement in another family's home. There may be more feelings of guilt, failure, or inadequacy associated with placement with different "parents" than with placement in a specialized treatment facility. Grealish and Meadowcroft (1989) indicated that the most powerful factor in reducing this resistance is the quality of the relationship between the natural parents and program staff. Staff efforts to include natural parents in the placement and service delivery process and to educate them about the goals of therapeutic foster care and the professional qualifications of treatment parents are essential aspects of the initial phase of service delivery.

Phase II: Intervention

Most programs develop an initial treatment plan based upon referral information obtained from the child's caseworker, therapist, natural family, school, and other sources coupled with direct observations during preplacement interviews and visits. Generally, a more formal treatment plan is developed following the child's first several weeks or month in the treatment home. The types of goals included in the treatment plan reflect the program's theoretical orientation to treatment (Snodgrass & Bryant, 1989). However, the plans commonly include a set of treatment goals to be achieved while the child is in the home; the long-term placement goal (i.e., return home, long-term substitute care, etc.); educational, vocational, mental health, or other special services to be provided; goals and services for the natural family; and plans for the child's contact and visitation with the natural family (Meadowcroft, Hawkins, Grealish, & Weaver, 1989). Ideally, the treatment plan is developed with the full involvement and participation of the program staff, treatment parents, natural parents, involved caseworkers and therapists, and the child, if appropriate. Some programs, such as the Professional Association of Treatment Homes (PATH) in Minneapolis, conceptualize the treatment plan as an explicit, written placement contract developed, agreed upon, and signed by all involved parties. Many programs assemble the full group on a quarterly basis to review the treatment plan and to make any necessary revisions and adjustments based upon an assessment of progress; other programs use a six-month time frame for evaluating progress and updating the treatment plan.

The actual services provided by therapeutic foster care programs fall within four broad categories: treatment services within the treatment home, support services to the treatment home, ancillary services, and services to natural families. The first three categories are described below; the services provided to natural families, as well as special issues and considerations in working with natural families, are discussed in a separate section.

o **Treatment Within the Treatment Home** - As noted, the primary function of therapeutic foster care is to provide treatment designed to enhance the child's adjustment. The foster family home serves as the treatment environment, offering a minimally restrictive and normalized treatment setting. Programs report that the supportive, family setting plays a major role in the therapeutic process, with the family and community interactions and activities providing opportunities for intervention. Thus, a critical ingredient of the treatment provided within treatment homes derives from the child's integration into a healthy family milieu. Further, the treatment parents are seen as the primary agents of treatment, with the major source of intervention deriving from the daily interactions between the treatment parents and the youngster (Meadowcroft, Hawkins, Grealish, & Weaver, 1989).

  In addition to the therapeutic family milieu, most programs provide treatment which can be defined as "planned interventions" to address troublesome behaviors. The specific strategies and methods used vary across programs due to differences in treatment philosophy. As previously indicated, many programs base their treatment approach on behavioral or learning-based technologies, but programs differ with respect to how consistently and formally these types of procedures are used. Meadowcroft, Hawkins, and colleagues (1989) noted that behavioral interventions can be conceptualized according to a continuum of structure or "naturalness" ranging from simple ignoring and praise, to easily implemented behavioral contracts, to more highly structured management methods such as point systems. PRYDE relies upon a point system or token economy as the basis of its treatment approach whereby points (or in some cases physical tokens) are exchanged for each occurrence or nonoccurrence of particular target behaviors. Most children's point systems are organized around three levels of privileges, allowing a child to obtain increasing rewards for improvements in overall performance. All children entering the PRYDE program begin with a point system, although the system may be phased out after consistently good performance over time. Special interventions, such as systematic desensitization, also may be used for specific problems.

  People Places employs a treatment model in which specific prosocial goals are taught and reinforced, and progress is documented on a daily basis. Despite its use of such a system, this program (along with the Lee Mental Health Center's Family Network Program, the Parent Therapist Program, and others) believes that the "broader, informal, socialization experience of stable family living over time is likely to have the most profound impact on the child's overall adjustment" (Meadowcroft, Hawkins, Grealish, & Weaver, 1989).

  Another aspect of the treatment provided in the context of the therapeutic foster home involves active teaching of appropriate behaviors and community living skills. The focus of such skill teaching varies according to the age, developmental, and functional level of each individual youngster; and the structure and formality of the teaching activities differs significantly across programs. Thus, the treatment provided within the treatment home consists of the interactions occurring within the therapeutic family environment, planned behavioral interventions with varying degrees of structure, and skill teaching. The relative emphasis on these various aspects of treatment and the degree of structure applied to treatment activities varies according to the program's treatment philosophy and according to the needs of different youngsters. One of the strengths of therapeutic foster care lies in the flexibility to tailor treatment approaches to the individual child (North Carolina Department of Human Resources, 1987).

o **Support Services to the Treatment Home** - In order to enable treatment parents to fulfill their role, therapeutic foster care programs provide a range of supportive services to the treatment home. Programs agree that the risk of burnout, frustration, and failure are reduced with the continuous availability of personnel and resources to assist treatment parents with their problems (Teaching Research, 1986). First and foremost, is the extensive consultation provided to treatment parents by program staff. As noted, staff visit homes regularly, reviewing progress and providing feedback, suggestions, and encouragement. A large proportion of this consultation can be conceptualized as in-service training that is practical and directly attuned to the challenges posed by the youngster placed in the treatment home at the time. Telephone contacts between staff and treatment parents occur as often as necessary, and both telephone and face-to-face contacts may be increased in response to the current situation in the particular treatment home. Consultation, training, and support also are offered to treatment parents through formalized inservice training programs, formal support groups, and informal support networks.

Respite care also is considered an essential support for treatment homes. Without provisions for relief, the program risks the stress, fatigue, and ultimate burnout of treatment parents. Respite care is provided on both a planned and emergency basis, and can be a valuable method for maintaining and strengthening placements. A variety of creative arrangements have been devised by programs to provide respite services within the treatment home or in another home setting (Meadowcroft & Grealish, 1989; North Carolina Department of Mental Health, 1987; Welkowitz, 1987). Some programs request that treatment parents identify persons within their own network of extended family and friends who may be interested in providing respite services. These individuals are then trained, and in some cases licensed, to provide respite care for emotionally disturbed youngsters.

Another approach involves recruiting and training individuals specifically to provide respite services and using them to fulfill this supportive function for many treatment homes. Treatment parents who do not wish to make a full-time commitment for periods of time or those without an active placement may be used as respite care resources, and in many cases programs encourage and assist treatment families in formulating cooperative arrangements to provide respite care for each other. Programs using the cluster concept, such as the Parent Therapist Program in Akron, Ohio, generally have one relief couple in each cluster. The relief couple is familiar to all of the children placed in five treatment homes within the cluster and is available three to four weekends per month, summer vacations, and other times as needed. In some situations, natural parents may provide respite for treatment parents or arrangements with a residential facility may be used for respite purposes. For example, the Northeastern Family Institute Professional Parenting Program provides two paid days off per month and seven paid days off per year for each treatment family. The youngster returns to the natural family, goes to another treatment home, or stays at the Northeastern Family Institute group home which has a respite bed. Meadowcroft & Grealish (1989) warned that care should be taken to ensure that the child does not feel rejected as a result of respite services and to avoid using respite as a strategy for problem resolution.

The availability of crisis intervention services, 24 hours-a-day, 7 days-a-week is an essential support for treatment homes. Treatment parents report that they are much more comfortable working with severely disturbed youngsters in their homes knowing that immediate staff back-up is available when they need it, that they are not "out there alone" in times of crisis. It should be noted that for less severe crises, treatment parents may first contact each other for support and assistance. In many programs, treatment parents are provided with the home telephone numbers of the staff person assigned to that case. Whether or not home numbers are provided, programs generally have some type of on-call system using pocket pagers or other arrangements to ensure that a staff person can always be reached. The on-call staff member is available to treatment parents for emergency consultation by phone as well as to provide in-home assistance in cases which warrant face-to-face crisis intervention. In many cases, discussing the situation with a staff person over the telephone provides enough support to enable treatment parents to handle the crisis on their own. Every attempt is made to keep the youngster within the treatment home while resolving crises by increasing the amount of staff consultation and support provided to the home and by other means. There are, however, some circumstances in which a youngster may be removed temporarily from the treatment home for a cooling off period, for stabilization, or to allow for investigation of an alleged offense. Other treatment homes, residential facilities, and hospitals are used by programs when appropriate and available.

Most programs publish clearly defined parameters for treatment parents regarding what constitutes a crisis situation warranting immediate notification to program staff. Kaleidoscope's Therapeutic Foster Family Program in Chicago requires treatment parents to immediately notify the program of: any arrest of a child or incident that results in legal action or involvement by the police; any accident or injury to the child; any allegation by a child or adult of physical injury, sexual assault, or threat of bodily injury from any source; any time the child is away from home without permission or has not returned home at the designated time; any complaints from school or neighbors about behavior of the child; any discovery of drugs, alcohol, weapons, or other illegal, dangerous material in possession of the child; any physical restraint or physical intervention with a child; and any emergency situation that might change the treatment family's or the child's living situation. Some of these situations require notification of the involved social services caseworker (e.g., medical emergencies), particularly if the child is in the legal custody of the social services agency.

Allegations of abuse or neglect against a treatment parent do occur, although these allegations are relatively infrequent according to many programs. Programs follow a set of specific procedures in these types of situations, including notification of supervisors and program administrators, notifying the social services agency, temporarily removing the child if necessary, implementing an internal investigation, determining whether notification of the state child abuse hotline is indicated, and reaching a decision about the course of action.

Additional personnel to provide assistance on a regular basis is another form of support that programs may provide to treatment homes. Some programs add child care workers or parent aides on a 40 hour-a-week basis or even round-the-clock to offer intensive support and supervision to children as well as to assist and relieve treatment parents and teachers. Parent aides often are provided with training and may be used in a variety of ways depending upon the needs of the youngster and treatment parents. Aides may accompany youngsters to school, assist teachers, provide after-school recreation or tutoring, assist treatment parents during particularly stressful or difficult times of the day, and more. The addition of parent aides is frequently found in the intensified versions of therapeutic foster care programs that are serving the most severely disturbed youngsters.

- **Ancillary Services** - Children in therapeutic foster care receive a number of additional services beyond the treatment provided within the context of the treatment home. These services may be provided by the program or agency, but more often are "brokered" by the program, i.e., program staff work with appropriate community agencies, systems, and personnel in order to obtain needed services. Two of the most significant of these services are mental health services and special education services. While treatment parents are considered primarily responsible for the child's treatment, there are situations in which it appears that assistance from a mental health professional might substantially enhance the child's progress (Hawkins, Meadowcroft, Trout & Luster, 1985). Mental health professionals may become involved in a consultive capacity, making recommendations to the treatment parents, staff, and school personnel in order to enhance their effectiveness. In other cases, psychologists, psychiatrists, or other mental health professionals may provide individual or group therapy to youngsters. The Northeastern Family Institute Professional Parenting Program, for example, encourages youth to attend individual therapy which provides the opportunity to privately discuss relationships with both the treatment family and natural family and to work independently on personal issues. Based upon their survey results, Snodgrass and Bryant (1989) reported that approximately 60 percent of the youth in therapeutic foster care are involved in individual or group counseling.

  Individual and group counseling related to substance abuse is a service increasingly sought for youth in therapeutic foster care. The Kaleidoscope's Therapeutic Foster Family Program has arranged for hospital-based detoxification services for youngsters followed by ongoing substance abuse services that are coordinated with the efforts of the treatment parents.

  A large percentage of the youth in therapeutic foster care require special education services. The importance of appropriate educational placements and services cannot be overstated, since, to some degree, the child's ability to succeed in therapeutic foster care depends upon the viability of the educational placement (Bauer & Heinke, 1976). As a result, close and effective working relationships with school districts in the communities served by the program are essential to the program's success. These working relationships are used to ensure that an appropriate educational placement is made for the child and that any needed special education services are provided. In addition, treatment parents and staff often consult with the child's teachers in order to coordinate efforts and to ensure consistent responses to the child's behavior at home and at school (Lanier & Coffey, 1981). Some programs employ school liaison specialists to interface with schools.

  Some therapeutic foster care programs, such as People Places and PRYDE, offer special education programs operated by their own agency. These special schools provide an educational resource for children who cannot function within the special education settings of public schools. The availability of this resource enables therapeutic foster care programs to work with more seriously disturbed youngsters who otherwise might not be accepted for therapeutic foster care due to the lack of an appropriate public school program (Snodgrass & Bryant, 1989).

  An array of other ancillary' services may also be provided, arranged, or brokered by therapeutic foster care programs (Lanier & Coffey, 1981; Webb, 1988). These include recreational services such as after-school and weekend programs, group activities programs, therapeutic outing programs, and therapeutic summer camping programs; vocational services such as job training programs and employment assistance; tutoring and extracurricular lessons in areas such as music, athletics, or crafts; and health services such as medical and dental care. Some programs arrange sex education (including AIDS education) for youngsters including instruction in and access to birth control in appropriate situations. An ancillary service provided specifically for older adolescents by People Places involves a ten-session Independent Living Skills Training Program which focuses on decision making, job planning, and clarification or personal goals and values.

Phase III: Discharge and Follow-Up

For many therapeutic foster care programs, discharge planning is begun during the initial phases of the placement. It is at this time that the treatment goals are established as well as the long-term placement goal indicating whether it is anticipated that the youngster will return to the natural family, progress to independent living, or require a long-term substitute care situation. Some programs, such as the Parent Counselor Program in Wilkes Barre, Pennsylvania, establish a projected date at the time of acceptance, although this can be revised based upon progress in the treatment home.

Therapeutic foster care services can be terminated prematurely for a number of reasons, including unsuccessful placements, court decisions, a change in the natural family, or for economic reasons (Meadowcroft, Hawkins, & Grealish, 1989). Under more favorable conditions, discharge occurs when the child has successfully achieved or made significant progress toward the goals established in the treatment plan and when an appropriate placement is identified and prepared for the youngster.

The average length of stay for youngsters in therapeutic foster care varies widely. Of the programs responding to this survey, the reported length of stay ranged from one month to five years. Across all respondent programs, the average length of stay is approximately 18 months. For the three programs described by Timbers (1989) -- PRYDE, People Places, and Professional Parenting -- the average length of stay is somewhat higher at approximately 27 months. The variance in average length of stay is attributable primarily to whether programs allow long-term or permanent placement in treatment homes or are designed for purposes of time-limited treatment. In their survey, Snodgrass and Bryant (1989) found that 73 percent of the respondent programs allowed for the possibility of permanent placement with treatment families, even if this resulted in loss of the subsequent use of the treatment home to the program.

The policies toward long-term placement in treatment homes are markedly discrepant across programs. Some programs regard therapeutic foster care as a viable long-term placement option, and encourage this for youngsters who cannot return home. Funding at the high rates of therapeutic foster care may even be continued on a long-term basis; this is considered preferable to the risk of destabilizing the youngster's situation. Kaleidoscope's Therapeutic Foster Family Program, for example, reported no pressure to move children to regular foster homes, and youngsters have remained in treatment homes for nine or ten years, or throughout their remaining years of childhood, when reunification is not a reasonable goal. In the Children's Garden Program in San Francisco, 90 percent of the youngsters are either adopted by treatment families or stay with treatment families in long-term foster care arrangements until emancipation (Beggs, 1987). People Places also allows for the potential permanence of therapeutic foster care as do the programs in Florida. In the Florida programs, however, while children may remain with the treatment parents following successful completion of the therapeutic foster care placement, the special stipend is discontinued so that treatment parents receive only the regular foster care payments (Friedman, 1980).

As noted, there are numerous programs, such as PRYDE and Futures Unlimited in St. Johnsbury, Vermont, which do not encourage long-term placement or adoption by treatment parents and clearly define their role as time-limited treatment. One of the major reasons for this policy is that highly trained and skilled treatment parents would be unable to continue their work as treatment parents if they adopted children (Welkowitz, 1987).

Once children are discharged from therapeutic foster care, follow-up or aftercare services may be provided. The purposes of follow-up services are to ensure a successful adjustment to the post-discharge placement and to see that needed ongoing treatment and services are provided without interruption. Hampson (1988) reported that some programs continue the intensive support to the child following discharge from therapeutic foster care to bridge the transition and to continue treatment plans in the new setting. More often, however, the follow-up component is either limited or totally nonexistent (Webb, 1988; Welkowitz, 1987). Generally attributed to lack of resources, the follow-up component of many therapeutic foster care programs consists of limited contacts for short periods of time. Typically, staff and treatment parents make follow-up contacts with the youngster consisting of occasional phone contacts and home visits and the availability of crisis intervention services for a period of several months following discharge. The frequency of contact decreases significantly after this initial period. People Places offers optional aftercare services which can be purchased by the social services agency, but this option is elected in only one out every ten cases (Meadowcroft, Hawkins, & Grealish, 1989).

More extensive follow-up is provided by the Lee Mental Health Center and PRYDE. The Lee Mental Health Center provides aftercare services for as long as necessary following discharge, with visits as often as weekly for the first months. PRYDE recently formalized a follow-through component which involves weekly phone contact and monthly visits for the first six months after discharge. A minimum of monthly phone contact is maintained during the next six month period. These programs, however, tend to be the exception rather than the rule. Social services caseworkers often are responsible for providing follow-up services, but their large caseloads make it difficult, if not impossible, for them to provide the intensive level of services, support, and coordination needed during the transition period.

The lack of more extensive follow-up services may have significant implications for the long-term effects of therapeutic foster care. Studies consistently have found that, regardless of the magnitude of the gains made in a residential treatment program, the post-discharge environment is an important factor in determining successful long-term adjustment (Whittaker & Mallucio, 1989). Thus, the supports that are provided following discharge from the treatment home may be as significant for long-term outcomes as the actual treatment provided during the therapeutic foster care experience. Whittaker and Mallucio argue that the implication for therapeutic foster care is that much more time and attention must be devoted to creating and maintaining support networks for the child and family once the formal service in the treatment home has ended. Additionally, they argue for a strong family intervention component for therapeutic foster care to enhance reintegration outcomes.

Staff and/or treatment parents may continue to serve as sources of support for the youngster and family following discharge. Programs increasingly are recognizing the importance of the follow-up component and are seeking funding sources to support improved aftercare. The Northeastern Family Institute in Vermont received funding for an aftercare program which enables the case manager to continue working with the youth in his or her new setting for a period of up to six months following discharge. Most programs agree that, ideally, services should be maintained until the youth is adjusted to the new setting, the family feels confident in the skills needed to cope with and serve as a change agent for the child, and the child and family are connected with a network of ongoing community support services (Welkowitz, 1987).

SERVICES TO NATURAL FAMILIES

One of the most challenging aspects of therapeutic foster care involves working with the natural families of children in treatment homes. This also represents one of the most inconsistent aspects of the service delivery approach; programs vary widely in the levels of effort and resources devoted to working with natural families, and, not surprisingly, in their effectiveness in reaching out to and successfully involving natural families (Webb, 1988). Early therapeutic foster care programs tended to be skeptical about the value of working with natural families, describing it as time-consuming and often fruitless (Fine, 1966; Waskowitz, 1954). The parents of troubled youngsters generally were regarded as emotionally disturbed themselves, and programs focused more heavily on working with the children and foster parents.

While these attitudes have changed somewhat, therapeutic foster care programs continue to report substantial barriers and difficulties in their efforts to work with natural families. One of the most commonly cited issues relates to the long-standing, multiple problems that many of the families have experienced. Programs reported that many of the families of youngsters in treatment homes have long histories of difficulties, including serious deficits in coping and parenting skills, substance abuse problems, histories of child abuse or neglect, histories of sexual abuse, erratic patterns of living together as a family unit, years of prior involvement with child welfare, mental health, or juvenile justice systems, and economic disadvantage. (Grealish, Hawkins, Meadowcroft, & Lynch, 1989). Across the three programs described by Timbers (1989), approximately 77 percent of the natural families had histories of marital discord; 51 percent had histories of substance abuse; 54 percent had histories of parental physical or sexual abuse; and 63 percent had histories of unemployment. These problems often make it difficult to engage families in the service delivery process, and progress is not easily achieved. Thus, many families are regarded as hard-to-reach, multi-problem, unresponsive, and unmotivated (Maluccio, 1981). Other impediments to working with natural families may be posed by geographic distances if the program serves a large area and by economic disincentives -- the cost of working with natural families may not be reimbursable to the agency (Maluccio & Whittaker, 1989; Whittaker, 1981).

Recently, in child welfare, mental health, and other service systems, there has been a major policy shift toward preserving families whenever possible and toward providing services to the family unit rather than automatically removing troubled children from their families and resorting to out-of-home placements. The preferred option has become to maintain family integrity and provide support to families, with an accompanying emphasis on reunifying families as quickly as possible in situations where out-of-home placement is unavoidable (Sinangolu, 1981). Sinangolu observed a burgeoning of attention to natural parents and an emerging recognition that parents are a "precious resource" for their children.

This increased emphasis on working with natural parents across child-serving systems has resulted from a number of factors. First, there has been a renewed appreciation of the meaning of biological belonging and of the importance, prominence, and strength of the bonds between children and parents. Regardless of physical separation or problems, the natural bonds between children and their parents remain powerful, and the biological family continues to exert a significant influence on the child's identity and sense of human connectedness (Watson, 1982; Maluccio & Whittaker, 1989). Given the significance of the natural family, it becomes important for therapeutic foster care programs (as well as other residential programs) to focus on the family and to help preserve family ties.

On a more practical side, it has been recognized that a substantial proportion of the children in residential care ultimately return home to their natural families. If families are not actively and effectively involved in the service delivery process, they do not have the opportunity to make the changes or develop the coping skills needed to more effectively handle their troubled child. Thus, the therapeutic gains made by the child in a treatment home or residential treatment environment may be negated when he or she returns to an unchanged home environment (Maluccio & Whittaker, 1989). A study of children in regular foster care revealed that most parents need special services to help them prepare for the return of the child and that many parents do not feel adequately prepared when their child returns home (Lahti & Dvorak, 1981). These findings may be even more salient to therapeutic foster care; natural parents are likely to need a range of special skills and community supports in order to successfully meet the demands of caring for a severely emotionally disturbed youngster. Regardless of the reason for the out-of-home placement, it seems clear that some changes in the home situation will be necessary in order to increase the likelihood of successful reunification following treatment and that services must be directed toward this goal. Further, it has been found that treatment in residential settings is more effective when programs involve parents (Sinangolu, 1981). Maluccio and Whittaker (1989) emphasized that parental involvement in the helping process and continuing parent-child contact are among the most prominent variables affecting the ultimate outcome of therapeutic foster care services.

The recognition of the crucial influence of the natural family in the child's ultimate adjustment has led to parent participation and involvement in residential treatment settings and attempts to design effective intervention approaches to use with natural families (Sinangolu, 1981; Watson, 1982). There is a growing consensus that natural parents should be engaged in the service delivery process and should be active and full participants in all planning and decisions about the care and treatment of the child. The implication for therapeutic foster care is that parents should be involved in service delivery unless there are overwhelming contra-indications for such involvement. Maluccio and Whittaker (1989) describe potential contra-indications as situations in which parental involvement can be demonstrated to be damaging to the child or situations in which parents are unable or unwilling to participate despite energetic, repeated, varied, and creative efforts to enlist their participation. Barring some of these conditions, they recommend that the family be viewed as the central unit of service although the child is in a treatment home. They further recommend that, even when the child is not likely to return home, parents participate in the planning process in a way that "reflects their caring, helps maintain their dignity, and frees the child to move into another family." In their view, parents should be seen as human beings with needs and feelings of their own, and the program's responsibility should extend to the natural family as well as to the youngster placed in the treatment home.

This focus on family participation and involvement in service delivery represents a significant change in attitude for many programs. Typically, mental health programs serving children offer natural parents a single role, that of client or patient. Whittaker (1981) noted that this practice is based on the belief that parents of troubled children are themselves troubled, disorganized, and in need of treatment. While this is certainly true in many cases, it is not universally the case. By limiting services to clinical treatment, programs overlook many other possible vehicles for enhancing family functioning and providing support, such as parent education and parent support groups. Additionally, Whittaker observed that even the most troubled families are not incapacitated all of the time and that they may be capable of participating in the program in many ways; he urged programs to identify and use opportunities for parents to become full and equal partners in the helping process.

Given this philosophy, Maluccio and Whittaker (1989) acknowledged that there is likely to be a continuum of parental involvement in therapeutic foster care, with the degree, kind, and purpose of involvement varying with the individual circumstances of each child and family. Family involvement might be minimal or nonexistent in situations in which parental rights have been terminated or there is no viable family unit; there would be maximal family involvement in situations in which reunification is the eventual goal. Between these extremes, family involvement varies according to the child's needs, parental motivation and behavior, treatment goals, and the like. The general guideline for programs to follow, however, is to encourage the maximum useful participation of parents.

While programs increasingly are recognizing the importance of family involvement, they report this to be a difficult and frustrating aspect of service delivery. Sustained effort and aggressive outreach may be needed to engage natural families in services, and, as a result, efforts to work with natural families often take a back seat to other programmatic activities (Beggs, 1987; Grealish, Hawkins, Meadowcroft, & Lynch, 1989; Horejsi, Bertsche, & Clark, 1981). The PRYDE Program, for example, found that staff make eight times as many phone calls and four times as many visits to treatment parents as they do to natural parents. Some programs provide counseling, "casework" (identifying and accessing needed services and supports), and parent training programs for natural families, but these services generally are not extensive and reach only a small percentage of families (Welkowitz, 1987). The results of the survey conducted by Snodgrass and Bryant (1989) indicated that 85 percent of the respondent programs provide some type of service to natural families, but that the type and intensity of these services are highly variable. Approximately 60 percent of the programs provide some counseling; one-third provide some casework; only one-quarter provide parent training; and others may simply help to arrange home visits for the child.

A range of methods for involving and providing services to natural families have been identified and used by therapeutic foster care programs. Some programs use written contracts with natural families to specify the types of involvement and services to be provided as well as to establish goals and time frames. The range of approaches includes:

- Parental Involvement in Service Delivery - Some programs regard parents as colleagues and active members of the treatment team. Every effort is made to involve parents in all aspects of the planning and delivery of services, including preplacement planning, establishment of treatment and placement goals, evaluation of progress, decision making regarding school placements and adjunct services, discharge planning, and so forth.

- Parental Contact with Youngsters - Most programs play a role in facilitating ongoing contact between the child and the natural family (Grealish, Hawkins, Meadowcroft, & Lynch, 1989). Decisions about the frequency and circumstances of visits are made on an individual case basis; state regulations may establish requirements for visitation. Some programs may not allow the child to return home to the natural family for a certain time period after initial placement in the treatment home, the rationale being that this helps the child to adjust to the separation and to form relationships with the treatment parents. In general, visits increase in frequency over time, and parental contact is increased further as discharge nears. Visitation may take place at agency offices, at the natural family's home, or at the treatment home. In addition, programs may encourage regular phone contact, sharing of special activities with natural families (e.g., birthday celebrations, recreational activities), and more (Whittaker, 1981). Visits not only allow for nurturing the parent-child relationship, but also allow youngsters to maintain their ties with siblings. Visits provide natural opportunities for staff to observe parent-child interactions and assist parents to build the skills and competencies needed to work more effectively with their children (Maluccio & Whittaker, 1989).

- Counseling - Most programs offer some type of counseling to natural families. This may be provided by the same staff person who is assigned to the youngster and treatment family, or mental health treatment may be provided by another professional. The counseling may be in the form of family therapy, involving the youngster along with the natural family, or therapy may be provided to the parents and/or siblings apart from the youngster who is in placement. Depending upon the family and the particular circumstances, counseling may take place at an agency office or via home visits. Natural families also may receive specialized counseling related to substance abuse or other specific problems.

- Casework - The casework services provided by programs involve identifying and obtaining the whole range of services, resources, and supports that the family may need in order to function more effectively and in order to meet the special needs of their emotionally disturbed child. Families who are economically disadvantaged may require assistance with respect to housing, income maintenance, job training, and employment. Services and supports to assist the family following the child's return home are commonly needed such as day care, special education services, respite care, and parent aides. In essence, programs broker and coordinate a range of services for natural families in order to help them to build an ongoing community support system for the child and family.

- Parent Education - Some programs provide special parent education or parent training activities for natural families. Such training may be provided in a group setting or it may be offered individually through staff interactions with natural families. Parent training efforts generally address skills including communication skills, relationship skills, and positive child management techniques as well as individualized approaches that are specific to the needs and problems of the particular youngster.

- Parent Support Groups - The most effective support for the parents of a handicapped child often comes from other parents who have had similar experiences (Whittaker, 1981). As a result, support groups offer a powerful resource to assist parents. Whittaker noted that parent support groups provide a relaxed atmosphere in which parents can get to know each other, share experiences, share strategies on handling troubled children, and receive encouragement. Further, parent support groups often lead to the development of ongoing, informal helping networks among parents.

  The PRYDE Program has found program-conducted support groups to be a cost-effective approach to working with natural families, one which offers certain distinct advantages. In addition to mutual support, the support group format provides opportunities for modeling, prompting, and reinforcing adaptive behavior as well as for obtaining interest and approval from a wide range of group participants. Based upon the program's experience, PRYDE has devised a series of working guidelines for this activity, including inviting parents only if they are likely to benefit from and contribute to the group; obtaining written commitments from parents to attend the next five meetings and comply with basic rules (e.g., not arriving under the influence of alcohol or drugs); providing reminder prompts including a letter and phone call before meetings; reimbursing transportation costs or providing transportation; providing babysitting services; providing refreshments at each meeting; arranging dinner visits with children prior to group meetings; providing staff to act as leader and logistics manager; conducting an "empowering" group process and minimizing the threatening quality of meetings; and starting where the parents are by addressing their most pressing concerns first (Grealish, Hawkins, Meadowcroft, & Lynch, 1989).

- Treatment Parents Working with Natural Parents - Some programs have found that treatment parents can serve as a substantial resource for natural families. The relationship between treatment parents and natural parents is one with an inherent potential for conflict. It is not unusual for regular foster parents to express antagonism and antipathy for natural parents, particularly in cases with a history of abuse or neglect in the home, and foster parents may fear for the child's return home. Additionally, there may be competition between the two families for the child's affection and loyalty, and differences in lifestyles and values may create difficulties in the relationship as well (Johnston & Gabor, 1981; Ryan, McFadden, & Warren, 1981). Some therapeutic foster care programs have made concerted efforts to redefine the relationship between the treatment parents and the natural parents in order to develop complementary roles. In effect, treatment parents are provided with appropriate training and support to help enhance the functioning of natural families. They provide emotional support to natural families, model healthy family relationships, provide advice and assistance on specific parenting and behavior management issues, provide knowledge of community resources, and may even provide direct assistance with some of the natural families' difficulties. Rather than competing for control or affection, treatment parents act as helpers and facilitators for the child and the family. Programs attempting to encourage this redefinition of roles report that, in some cases, natural parents are more comfortable discussing problems and difficulties with treatment parents than with professional staff. The relationship is less formal, and treatment parents may seem more approachable than professionals (Johnston & Gabor, 1981; Seaberg, 1981). Thus, treatment parents can provide services to natural families by assuming a supportive role and by sharing their skills and expertise in behavior management and parenting troubled children.

Regardless of the specific approaches used to work with natural families, Maluccio and Whittaker (1989) advocate adopting a "competence perspective" or growth orientation. The competence perspective involves using approaches that empower parents, that regard parents as resources and partners in the helping process rather than simply as carriers of pathology. The competence perspective requires programs to shift from a pathological model (where the child's problems are seen automatically as reflecting the pathology of the parents) to an ecological model. This approach emphasizes identifying and capitalizing on the family's strengths; translating problems into adaptive tasks or skill deficits that a family can work on; providing a variety of interventions to enhance family functioning; and accessing community resources and supports to maintain family functioning.

LINKAGES

Therapeutic foster care programs depend to a great extent on effective working relationships with a wide variety of community agencies and resources. While residential treatment centers and hospitals are self-contained and provide their own educational, vocational, medical, recreational, and other services, therapeutic foster care programs must look to the community for opportunities (Meadowcroft & Luster, 1989). Therefore, linkages must be developed and nurtured with a wide range of agencies and professionals in order to meet the specialized needs of youngsters in treatment homes. Programs generally develop such linkages with school systems, agencies providing vocational services, child welfare agencies, mental health agencies, juvenile courts, medical and dental professionals, professionals providing specialized services related to such problems as substance abuse and sexual abuse, and recreational resources such as boys' clubs, Big Brothers/Sisters organizations, and scouts. These linkages allow programs to enlist a host of community resources to support therapeutic foster care services.

Of particular importance is the need to coordinate services with the referring agency and worker. A variety of methods are used to ensure that the referring agency is kept informed of progress and problems and has active input into the treatment and service plans, participation on the treatment team, regular progress reports, judicial progress reviews, immediate reporting of critical incidents, monthly luncheons involving program staff and referring caseworkers, and ongoing telephone contact (Meadowcroft, Hawkins, Grealish, & Weaver, 1989).

Perhaps the most critical linkage for therapeutic foster care programs is with school systems. Children spend nearly as much time in school as they do at home, and it has long been recognized that a child's failure to adjust to school creates insurmountable difficulties for even the most skilled treatment parents. Ambinder and Falik (1966) contended that a youngster's prospect of successful adjustment in a treatment home will be greatly improved to the extent that the agency can work effectively with the school.

A substantial percentage of the children in therapeutic foster care experience problems in school, and many require special education services of some type. However, arranging for and maintaining appropriate educational placements can present significant difficulties for programs (Meadowcroft, Hawkins, Grealish, & Weaver, 1989; Welkowitz, 1987). In some school districts, appropriate special education services simply may not be available. Other districts may be reluctant to accept foster children with special needs for a variety of reasons: the youngsters may be viewed as potential troublemakers; school systems may be reluctant to bear the costs of special education and support services for youngsters who do not technically live in the district; there may be no mechanism for transferring funds to support special education from the youngster's original home district; school districts may resent the transfer of youngsters to their schools with little advance warning; and so forth. There are few therapeutic foster care programs that have not encountered resistance from local school systems to accepting and providing special services to the severely disturbed youngsters placed in treatment homes.

Because of the critical impact of the child's educational placement, and because of these potential problems, most therapeutic foster care programs devote a great deal of attention to their relationships with the school districts in the area they serve. Sometimes a program may relate to numerous school districts within their catchment area. PRYDE, for example, deals with more than 25 school districts in Allegheny County alone. Programs, such as the Lee County Mental Health Center's Family Network Program, have a special staff person to fulfill the role of educational liaison. In other programs, the staff member working with a particular child and treatment home also is responsible for coordinating services with the appropriate school district and educational personnel. The first task is to shape the school experience and placement to fit the child's needs, and the ongoing task involves providing whatever supports are needed to successfully maintain the child in the school situation and to enhance progress. Strategies for working with schools include involving school staff in the preplacement decision making process; informing schools of the arrival of new children in advance; involving school personnel in planning for the child; maintaining close and ongoing communication with teachers and other involved school personnel (even daily written communication when needed); providing aides, tutors, and any other supports needed to work with the child in school; and responding promptly and effectively to school requests for support or intervention (Meadowcroft, Hawkins, Grealish, & Weaver, 1989). Some programs have access to special education schools run by their own agencies for the small percentage of youngsters who cannot attend the less restrictive special education programs offered by the public school systems.

Another significant linkage is between child welfare and mental health agencies. Many programs are jointly funded and/or jointly operated by these two systems, requiring close working relationships (Carros & Krikston, 1989; Goldstein, Gabay & Switzer, 1981). Mental health and child welfare agency personnel indicate that the interchange between the two agencies around the therapeutic foster care programs often creates a forum for joint planning and problem solving related to larger interagency service delivery and policy issues. Since the therapeutic foster care model is highly dependent upon coordination between child welfare and mental health systems, it is important to overcome the turf issues and lack of coordination which often typify their relationship (Snodgrass & Bryant, 1989). A strategy used by the Lee Mental Health Center involves weekly meetings with the child welfare agency supervisor and monthly meetings with all child welfare staff for case review purposes.

In addition to these linkages, therapeutic foster care programs may implement strategies for coordinating services across the multiple agencies that may be involved with youth. Some use interagency coordinating committees to screen children for admission to the program and for other purposes (Gold Award, 1977); most programs include representatives from all involved agencies on the treatment team responsible for ongoing treatment planning and progress evaluation for each individual child. Additionally, one of the responsibilities of program staff is to serve as liaison with the variety of involved community agencies and to play a case management or coordinating role in service delivery.

One of the problems cited by programs involves resistance or negative attitudes on the part of community agencies toward therapeutic foster care. Negative attitudes may stem largely from misconceptions about the nature of therapeutic foster care, incorrect assumptions about the types of children that can be served in therapeutic foster care, feelings of insecurity or lack of control, or fear of the unknown (Barnes, 1980; Grealish & Meadowcroft, 1989). There is broad agreement that a solid base of support is needed for a therapeutic foster care program and that it is important to garner understanding, cooperation, and support from schools, courts, social service agencies, police, and even neighbors. Grealish and Meadowcroft suggest consistent efforts to increase knowledge of the program among community agencies and to establish open, cooperative relationships. Efforts might include mailing informational or promotional materials, inviting agency representatives to observe or participate in training activities, and making presentations to community agencies.

CLIENTS

The client population that can be served within therapeutic foster care is broad and diverse. The model has the inherent capability to adapt to special needs by selecting a treatment home based upon the individual needs and characteristics of the client as well as by designing a treatment program and interventions specifically for each youngster. While programs may serve more than one population, many therapeutic foster care programs are designed to serve children with significant emotional and/or behavioral problems (Update, 1986). Snodgrass and Bryant (1989) reported that of the programs included in their survey, 91 percent serve children with emotional/behavioral disorders, and more than half identified this population as their primary focus. Forty percent of the programs identified their primary focus as "severely emotionally disturbed children." Of the 30 plus programs in the literature reviewed by Webb (1988), nearly two-thirds described their populations as emotionally or behaviorally disturbed. In addition to having serious emotional and behavioral problems, the children in therapeutic foster care are characterized as being at high risk for placement in more restrictive treatment settings. Thus, the client population is characterized as seriously disturbed and at high risk for placement in group homes, residential treatment centers, psychiatric hospitals, and the like.

Some agencies and professionals remain skeptical about the viability of providing treatment for seriously disturbed youngsters in family settings. The experience of therapeutic foster care programs, however, suggests that some of the most disturbed and disturbing youngsters can be served with this approach, including some youngsters who could not be served successfully within group or institutional settings (Bryant, 1983). Meadowcroft (1988) emphasized that the ability to serve a child successfully in therapeutic foster care is determined by the program's strengths and the availability of highly skilled treatment families, not by the type or severity of the child's problem. She contended that with the proper treatment and community resources, a large percentage of children currently in psychiatric hospitals, group homes, residential treatment centers, or detention facilities could be served effectively in family settings. This contention is supported by data comparing 100 therapeutic foster care clients with 1000 youths served by group homes subscribing to the Teaching Family model. The comparison revealed that the youngsters in therapeutic foster care were comparable to, if not more disturbed than, the youngsters placed in group homes (Jones, 1989).

Most of the programs responding to this survey serve youngsters through age 18 or 19 (77 percent). Approximately 20 percent of the programs extend the upper age limit for therapeutic foster care to 21 and in one case to age 24. The lower age limit for therapeutic foster care programs appears to be somewhat more variable. Approximately 45 percent of the respondent programs accept infants and preschoolers (ages 0 to 4); 36 percent set their lower age limit between ages 5 and 8, thereby accepting only children who have reached school age. Nineteen percent of the programs establish a lower age limit between 11 and 13 years of age, limiting their client populations to adolescents. Programs appear to serve slightly more early adolescents than any other age group, with approximately 32 percent of the clients falling into the age 13 to 15 category. Across programs, 29 percent of the children served are ages 6 to 12, and 26 percent of the children served are ages 16 to 17. Far fewer children are over age 18 (8 percent) or under age 5 (5 percent).

The therapeutic foster care programs included in the survey appear to serve a higher percentage of males (57 percent). The racial characteristics of the client population vary widely with the location of the program. Across all programs, approximately 66 percent of the children served are white and 29 percent are black. The remainder of the client population is comprised of minority groups including Native Americans (2 percent), Asians (2 percent), and Hispanics (1 percent). Therapeutic foster care programs report considerable success in serving minority children in a culturally sensitive manner. By recruiting minority treatment parents, programs can meet the child's treatment needs along with his or her cultural and ethnic needs (Meadowcroft, 1988). The PRYDE Program, for example, has been successful in recruiting black treatment parents from the Pittsburgh metropolitan area and is able to provide culturally sensitive services to a sizeable population of urban black youngsters (Timbers, 1989).

Most of the children in therapeutic foster care have extensive histories of previous out-of-home placement (often in more restrictive settings) and of previous mental health treatment. Data presented by Timbers (1989) describing the populations served by PRYDE, People Places, and Professional Parenting suggest a striking pattern of previous placements. On average, children in these programs have had 3.6 previous placements and have been in out-of-home placements for approximately 4 years prior to entry into therapeutic foster care. The range of prior out-of-home placements experienced by children in these programs includes emergency shelters, groups homes, foster homes, psychiatric institutions, relatives, and child care institutions. The treatment histories of the youngsters in therapeutic foster care also appear to be significant. The histories of children in Florida's therapeutic foster care programs revealed that nearly two-thirds had received outpatient mental health treatment and one-third had at least one prior psychiatric hospitalization; more than half had received special education services (Friedman, 1980; 1981). From approximately 10 to as many as 40 percent of the children served by therapeutic foster care programs are reported to be on psychotropic medications.

Another commonality in the backgrounds of youngsters in therapeutic foster care appears to be a history of physical or sexual abuse. For the three programs described by Timbers (1989), approximately half of the children served have been victims of physical abuse and one-quarter to one-half have been victims of sexual abuse. Some programs report that as many as 80 percent of the youngsters served have experienced physical or sexual abuse (Beggs, 1987).

With respect to diagnoses, most programs characterize the children as having emotional disorders (50 percent of the children served) or behavioral/conduct disorders (43 percent of the children served). A much smaller percentage of the client population (15 percent) is considered to have schizophrenia or other psychoses. It should be noted, however, that programs may have used different definitions to distinguish between these categories, and there may be considerable overlap. While the diagnoses assigned by different programs are highly variable, many programs require that children have a DSM III diagnosis in order to be considered for services.

Despite the inconsistency in diagnostic labeling, programs do provide behavioral descriptions of the youngsters they serve. The difficulties and symptoms ascribed to children in therapeutic foster care programs include a wide range of behavioral problems, difficulties in school, and psychopathology (Snodgrass & Campbell, 1981; Timbers, 1989; Webb, 1988; Welkowitz, 1987; Witters & Snodgrass, 1982). The behavioral/conduct problems cited include poor peer relationships, noncompliance, running away, verbal and physical aggression, tantrums, stealing, sexual acting out, drug use, destructive behavior, truancy and serious school problems, enuresis and encopresis, sleep disturbances, and hyperactivity. A significant percentage of children exhibit serious psychiatric symptoms including depression and withdrawal, suicidal tendencies, hallucinations or delusions, mood swings, anxiety, and others.

Therapeutic foster care programs readily acknowledge that they cannot replace institutional services entirely. There are a range of clients who cannot be accepted by therapeutic foster care programs, primarily because they may present a serious threat to themselves or to others within the treatment home or community. Most programs do not accept children with extreme problems such as:

- Chronic or recent histories of fire setting
- Chronic or recent histories of violence
- Chronic or recent histories of sexual offenses
- Primary and severe problems of substance abuse
- Active and serious suicidal behavior
- Active and unstabilized psychoses
- Severe retardation

Other problems which might preclude admission into some programs include chronic runaway behavior, chronic and serious history of criminal activity, serious neurological impairments, serious physical disabilities, pregnancy, or situations in which the youngster is adamantly opposed to the placement. It should be recognized that programs do accept children with nearly all of the above problems; the decision is based on the **severity**, **recency**, and **chronicity** of the problems and an assessment of whether or not the problem puts the treatment family or the community at risk. Therapeutic foster care cannot offer the degree of protection for the client and the community that can be provided in more restrictive settings, but many seriously disturbed youngsters can be served effectively in the less restrictive, family settings as long as the behavior in question does not pose a serious, imminent danger.

At this time, there is little empirical basis for predicting which types of children can be served most effectively in therapeutic foster care and which types of children are most difficult to serve with this model. The experience of People Places suggests that children with a combination of retardation (IQs below 65) and significant behavior problems pose particularly difficult challenges for treatment parents over time. Older adolescents who appear determined to shed any bonds of family control also may be more difficult to serve effectively in treatment homes (Bryant, 1983). Bryant cited limited data which indicates somewhat greater success with younger children who have not had previous out-of-home placements, but he stressed the need for more rigorous research on outcomes for various client groups receiving therapeutic foster care services. The need for research is underscored by the conflicting experience of other programs. For example, PRYDE experienced success with a pilot effort to provide therapeutic foster care services to youngsters with the dual diagnosis of mental retardation and emotional/behavioral disorders. A new program, Home Places, was subsequently launched to provide therapeutic foster care to this client group.

As noted, the therapeutic foster care approach is uniquely capable of serving a wide range of special populations. Programs adapt their services to different types of clients by providing specialized training for treatment parents, adding professional staff with various types of expertise, and designing specialized treatment interventions for the client population in question. Autistic, developmentally disabled, and dually diagnosed children are among those who can be served in therapeutic foster care settings given appropriately skilled treatment parents and staff. The intensive versions of therapeutic foster care programs, which often involve assembling a team of professionals and aides to assist the treatment parents, have demonstrated potential for serving the most seriously disturbed, and even seriously violent, clients. Meadowcroft and Luster (1989) pointed out that children with serious medical needs can be served in treatment homes. Nurses or other persons with medical backgrounds can be recruited as treatment parents and paid a salary comparable to a hospital employee, and the home could be equipped with needed medical equipment. While serving children with medical needs may be expensive, the costs are significantly less than the costs associated with extended hospital care.

Kaleidoscope has adapted its therapeutic foster care program to serve two special populations -- adolescent parents and young children with AIDS. In the Adolescent Parent Program, the treatment parents help the pregnant teen through the process of childbirth, provide a supportive environment for the adolescent mother and baby, teach the mother parenting skills, and provide babysitting so that the teen mother can complete school or vocational training. The Specialized Team for AIDS Relief (STAR) Program provides treatment homes for infants and toddlers with AIDS. Kaleidoscope recruits and trains treatment parents specifically to provide nurturing, therapeutic environments for children with AIDS. The program addresses the complexities of the medical, educational, legal, social, and emotional needs of these children, striving to meet these needs in the most normalized way.

Although therapeutic foster care is adaptable to a diverse population of children, Meadowcroft and Luster (1989) recommend that programs limit the population served in the initial phases of program development. An excessively broad client population may strain the program and staff as well as confuse referral sources. When a program has established a track record with a well-defined population of youngsters, it may then expand and modify its approach to serve additional client groups.

A further caveat regarding the clients served involves ensuring that youngsters served in therapeutic foster care actually need out-of-home care and could not be served using even less restrictive interventions (Friedman, 1989; Meadowcroft, 1988). It is increasingly recognized that the provision of intensive, nonresidential services often can avert the need for out-of-home care. Home-based services, for example, involve providing highly intensive counseling and support services to seriously disturbed children and families on an outreach basis. These services have proven successful, in many cases, in maintaining family integrity and in improving family functioning (Stroul, 1988). Given the success of home-based services, intensive day treatment, and other approaches, youngsters should have the opportunity to receive these services prior to being removed from their own homes. Thus, while therapeutic foster care offers the least restrictive residential treatment environment, these services should be provided within the context of a system of care which offers an array of intensive, nonresidential services as well.

The legal custody of children in therapeutic foster care is an aspect of this approach under some deliberation. Based upon state regulations, many programs require that children placed in treatment homes be in the legal custody of the child welfare agency. In some cases, the child is already in the custody of the child welfare agency at the time of referral, previously removed from the home for reasons of protection. Additionally, some children are the responsibility of the juvenile justice system as a result of status offenses or adjudication as delinquents. When this is not the case, the child's parents or legal guardians often must voluntarily accept a legal transfer of custody to the child welfare agency for the duration of the child's placement in a treatment home. While legal custody is temporarily relinquished by parents, parental rights are not. There is some variation among states, however, in the extent of rights and responsibilities retained by parents when such voluntary custody agreements are executed (McManus & Friesen, 1989). Programs report that many parents will agree to this procedure in order to obtain therapeutic foster care services for their child.

For increasing numbers of parents, however, there is significant discomfort and outrage at the notion of relinquishing legal custody, even temporarily, in order to receive treatment. These parents have not abused or neglected their children, but rather are taking this step in order to comply with regulations or because they cannot afford the full cost of residential treatment. As a result, when faced with costly placements in treatment homes as well as in residential treatment centers and similar settings, parents may be forced to transfer custody to the child welfare agency. There is increasing awareness of the social and psychological consequences of relinquishing legal custody in order to obtain treatment (Fine & Friesen, 1988; McManus & Friesen, 1989). This action may create impediments to parental involvement in treatment; they may not be consulted about decisions or simply may feel alienated from the service delivery process. Further, even though the transfer of custody is voluntary and intended to be temporary, the perception that the parents do not want the child may linger in the minds of the parents, child, siblings, and others. Negative impacts on the prospects for family reunification also may result from surrendering custody as well as a more pronounced psychological separation between the parents and child.

Some states use models which avoid the legal separation, through written voluntary placement agreements. The time limits and procedures vary according to state law and may be cumbersome, with frequent reviews required. Despite these problems, parents feel much more comfortable with voluntary agreements that do not involve a legal transfer of custody. A recent survey revealed that at least 29 states have provisions for voluntary placement which allow parents to agree to out-of-home placement for periods ranging from 30 days to 6 months without surrendering legal custody (McManus & Friesen, 1989). The provisions of Iowa's statutes allow these voluntary placement agreements to be renewed for the additional periods of time needed to continue treatment. An example of the use of voluntary agreements is provided by the therapeutic foster care program at the Smokey Mountain Mental Health Center in North Carolina. The program accepts children on the basis of a written placement agreement signed by the natural parents which serves as a consent for treatment in a therapeutic home; a release for emergency medical services also is required.

Most agree that there should be more emphasis on the use of voluntary agreements that avoid the transfer of legal custody coupled with efforts to involve and include the natural parents in all phases of service delivery. McManus and Friesen (1989) emphasized that it is unconscionable for parents to be faced with the "Hobson's choice" of relinquishing legal custody or not receiving services and that "parents should be able to secure necessary (but unaffordable) services for their children with emotional disabilities at public expense, participate in decision making and treatment planning, and retain legal custody throughout the duration of the children's receipt of out-of-home services."

STAFFING

The key staff position in therapeutic foster care is that of the counselor, given a variety of titles by different programs such as case manager, program manager, treatment parent supervisor, parent supervisor/community liaison, and the like. The counselor plays a pivotal role in therapeutic foster care and has direct supportive and supervisory responsibilities to the treatment parents, children, and natural parents (Barnes, 1980; Meadowcroft, Luster, & Fabry, 1989; Russell & Silberman, 1979; Snodgrass & Bryant, 1989; Welkowitz, 1987). In relation to treatment parents, the counselor's role involves providing in-home supervision, training, consultation, and support through frequent visits and telephone contact as well as 24-hour crisis assistance. For the children, the counselor is responsible for coordinating the development of the treatment plan, monitoring treatment implementation and progress, and often providing informal counseling and support to the youth. The counselor's role includes accessing and coordinating needed community services and supports for the child, with particular attention to consulting and coordinating efforts with the schools. Additionally, the counselor coordinates discharge planning and provides follow-up services to the child when the intervention is completed.

The counselor's role extends to the natural parents and encompasses providing direct counseling and parent education to natural families as well as assistance in accessing resources and supports needed to improve family functioning. Thus, the counselor's role crosses the boundaries of traditional clinical services, combining clinical functions with supervision, training, support, coordination, and advocacy functions. Counselors in therapeutic foster care programs are generalists, essentially serving as both clinicians and case managers. Even when the child's official case manager is a staff person from the child welfare agency, the therapeutic foster care program staff fulfill a case management role, handling all aspects of the child's care and doing whatever is needed to support the child and treatment parents.

Some programs have experimented with splitting these various functions by using different staff to work with natural families or by separating clinical and "casework" or "social work" functions, for example. The experience of many programs, however, suggests that it is most effective for one staff person to work with the treatment parents, child, and natural parents and for that staff person to be responsible for doing whatever is necessary. These front line staff persons have primary responsibility for each youngster and generally are given considerable autonomy and flexibility.

In addition to these duties, staff often are assigned responsibility for other program tasks such as recruiting and selecting treatment parents, assisting in the preservice and inservice training of treatment parents, handling referrals and intakes, assisting in program development or evaluation activities, and the like. Of the programs included in the survey conducted by Snodgrass and Bryant (1989), 76 percent indicated that staff is required to perform these types of duties in addition to their work with treatment parents, children, and natural parents.

To allow for these many and varied responsibilities, staff of therapeutic foster care programs typically have small caseloads. In the Snodgrass and Bryant survey (1989), 79 percent of the respondent programs reported caseloads of fewer than 20 youngsters, with an average caseload of 12.5 youngsters per staff person. Even early therapeutic foster care programs recognized the importance of small caseloads to permit frequent contact and active involvement with each child and treatment family (Waskowitz, 1954). The importance of low caseloads continues to be emphasized in order to ensure that staff can provide maximal support and assistance to treatment parents, children, and natural families (Friedman, 1981). Barnes (1980) recommended that caseload size not exceed 12 during the initial phase of a program's operation; after the program and staff become more experienced, caseload size might be expanded to a maximum of 15. Larger caseloads would preclude staff from providing the level of services needed. Hawkins (1987) recommended even smaller caseloads -- seven cases per staff or as few as three cases for the more intensive versions of therapeutic foster care which serve the most severely disturbed youngsters. If staff are to be assigned additional duties (e.g., recruitment and training), caseloads, of necessity, must be lowered accordingly (Meadowcroft, Luster, & Fabry, 1989).

Some programs subscribe to a team approach, assigning two staff persons to each case. At People Places, for example, two professional staff persons are assigned to each youngster upon admission. A "program manager" works most intensively with the treatment parents, providing training and consultation, identifying and coordinating community resources, consulting with public schools, serving as an advocate, and providing 24-hour crisis assistance. A "program supervisor" at the master's or doctoral level also is assigned to the case to provide frequent consultation and support to the program manager, input into the development and review of treatment plans, and emergency back-up. Additionally, the program supervisor meets with the child on a monthly basis. A similar approach is used by the Kaleidoscope Therapeutic Foster Family Program which assigns a two-person team comprised of a foster family worker and a social worker to each child.

Other programs, such as PRYDE, organize staff into teams of five or six counselors led by a supervisor. These staffing patterns allow for regular and frequent supervision and consultation. Many programs provide formal supervision to staff through weekly case review and consultation sessions; informal case consultation and discussions occur daily through staff interactions. Emergency back-up and case consultation is available to line staff from supervisor and administrative personnel at all times.

Many therapeutic foster care programs rely on bachelor's level staff to fulfill the counselor's role. While staff with advanced degrees (master's in social work, psychology, counseling, or special education) may be preferred, programs typically do not offer sufficiently high salaries to attract highly trained professionals (Welkowitz, 1987). In reviewing therapeutic foster care programs in Florida, Friedman (1981) found that programs had dedicated staff but not always with the requisite training and experience needed for the job; some programs lacked even one staff person with an annual salary exceeding $15,000. The need for qualified and technically competent professional staff for therapeutic foster care programs is increasingly apparent, both for front line counselor and supervisory positions (Friedman, 1981; Meadowcroft, Luster, & Fabry, 1989).

In addition to minimum academic credentials, most programs require staff to have considerable previous experience working with troubled youngsters and families. Some programs look for staff with experience or training in behavior analysis and behavior management. Since few academic institutions or traditional mental health agencies provide training or experience specific to therapeutic foster care, programs emphasize hiring individuals with strong potential and with a willingness to learn the necessary skills.

Although programs adhere to academic and experiential requirements, there is agreement that an array of personal characteristics may be of greater importance for the job. These include such qualities as high energy level, enthusiasm and optimism, commitment, resourcefulness and creativity, flexibility, assertiveness, resilience, and good communication and counseling skills. Staff must be able to relate effectively to many different types of people -- treatment parents, troubled children, natural parents, and personnel from other agencies. They must be willing to spend most of their work time not in an office setting but in treatment homes, natural families' homes, schools, and elsewhere in the community. Further, they must be willing to work according to a flexible schedule which includes evenings, weekends, and 24-hour emergency availability. In short, staff of therapeutic foster care programs must have personalities and life circumstances that are well-suited to nontraditional schedules and roles. On a more practical level, the job necessitates that staff members be able to drive and have their own cars.

The line counselors and supervisors in therapeutic foster care programs often are supported by a number of supplementary staff. One of the more common supplementary staff positions is that of an educational specialist who serves as a liaison between counselors and schools

(Davis, Jemison, Rowe, & Sprague, 1981). As noted, the linkage with school systems is critical to the success of therapeutic foster care, and programs may interact with numerous school districts. Additionally, schools may be resistant toward serving children with special needs and serious emotional and behavioral problems. The educational specialist generally has in-depth knowledge of special education legislation and requirements and can serve as an advocate for the child in order to ensure that appropriate educational services and placements are provided. Further, the specialist can assist in developing the youngster's educational plan, monitoring school progress and performance, consulting with school personnel regarding effective approaches for handling the child, problem solving, and coordinating the efforts of program staff, treatment parents, and school personnel.

Psychiatrists and psychologists may be part of the staff of therapeutic foster care programs, frequently on a part-time or consultant basis. Psychiatrists are used to evaluate referrals and sometimes prospective treatment parents, to assist in the development of treatment plans, to prescribe and monitor medications, and to provide clinical consultation to staff. Psychologists are used to conduct psychological evaluations of children when indicated, to assist in treatment plan development, to provide consultation to staff and treatment parents, and to conduct research and evaluation activities. Both psychiatrists and psychologists may provide direct therapeutic services to individual youngsters in appropriate situations.

A number of programs have staff positions specifically focused on treatment parent recruitment and treatment parent training. Full-time or near full-time recruiters and trainers are necessities in larger therapeutic foster care programs which must devote significant effort to these functions in order to keep pace with demand. Having specialized staff to fulfill these roles frees counselors to concentrate more on their work with youngsters and families, although staff generally are still expected to have some involvement in recruitment and training activities. Treatment parent aides are another type of supplemental staff employed by programs to support and assist treatment parents with particularly challenging children. Aides are assigned to the treatment home and/or school for a specified number of hours per week, or even around-the-clock if necessary. Less frequently, programs provide nurses or homemakers to serve treatment families, children, and natural families.

Most programs offer some type of training opportunities for staff. As noted, educational institutions offer few courses or content specific to the needs of therapeutic foster care workers, whether the discipline is social work, counseling, or psychology. Besides the fact that therapeutic foster care represents a nontraditional approach, staff need skills in working with different age groups (children and parents) and populations, and they require skills in teaching, consultation, and supervision as well as in individual and family counseling and resource brokering. Thus, there is a significant gap between preservice preparation and the actual demands of the job (Russell & Silberman, 1979). Programs may offer an orientation with varying degrees of formality, and may require that new staff participate in the full training program required for treatment parents. Experienced staff often are used as teachers and mentors for new staff members.

Additionally, most programs offer inservice training opportunities for staff on a wide variety of relevant topics. Inservice training topics at PRYDE have included current child sexual abuse laws, suicide, handling crises, runaways, and working with the courts. Many programs encourage staff to take advantage of professional development opportunities such as conferences and workshops and may provide some funds to subsidize this participation. The PRYDE Program arranged a unique opportunity for staff to obtain a master's degree over a three-year period while working in the program through the special education department of a local university (Meadowcroft, Luster, & Fabry, 1989). While individual programs attempt to fill the educational void, there is a need for educational and training opportunities that are relevant and specific to the therapeutic foster care approach (Bryant, 1980a; 1981).

Demands on therapeutic foster care staff are high, and "burnout" is an ever-present risk. Staff are expected to work with children, treatment parents, natural parents, and community agencies and to fulfill a wide variety of roles and functions; they are expected to work evenings and weekends and to be on call for emergencies. The potential stresses involved in the job are considerable, and programs tend to pay close attention to the needs of staff in order to avoid burnout and excessively high staff turnover rates (Meadowcroft, Luster, & Fabry, 1989; Webb, 1988; Barnes, 1980). Strategies include:

- o Creating a supportive atmosphere for staff including frequent opportunities for sharing and mutual support among staff: lunches, parties, and other events to build camaraderie and morale.
- o Providing adequate compensation in the form of salaries that are competitive with other local agencies, good employee benefits, and compensation time for overtime worked.
- o Providing staff development and professional development opportunities and encouragement for staff to achieve their own personal goals.
- o Implementing an "empowering" administrative style including autonomy and encouragement for creative problem solving, staff involvement in program decisions, treatment of staff with dignity and respect, and visible recognition for successes and accomplishments.
- o Providing back-up consultation and support from supervisory and administrative staff at all times.

A strategy used by People Places allows direct service staff to work four 10-hour days and take Fridays off (although they remain on call). This arrangement has had a significant impact on staff retention.

The importance of providing adequate compensation for staff was recognized by a consultant enlisted by the PRYDE Program to examine a problem with staff turnover. The consultant recommended higher starting salaries for staff in order to attract more experienced individuals and to enhance employee satisfaction and commitment. Workers' salaries in therapeutic foster care must be high enough to compensate for the late and irregular hours and the additional stresses involved in the job.

TREATMENT PARENTS

Role and Characteristics

One of the major distinguishing factors of therapeutic foster care is the role of the treatment parents. As noted, primary responsibility for treatment rests with the treatment parents and not with professional therapists and caseworkers. Program staff and other professionals provide consultation to treatment parents, assisting them and supporting them in their role as primary treatment agents. Treatment parents are key participants in the process of establishing treatment goals and designing treatment strategies; they implement the treatment program in the context of their treatment homes; and they represent the primary data source for assessing progress. Thus, treatment parents play a vital role in the therapeutic foster care intervention and are considered a central part of the treatment team.

The role of treatment parents, of course, is not limited to treatment per se. A range of other responsibilities, more commonly associated with regular foster care, is included in the job description of treatment parents. These responsibilities include providing adequate shelter;

providing a nutritious diet; ensuring that children have adequate clothing and are dressed appropriately; assisting youngsters in developing good grooming and personal hygiene habits; providing a structure that is appropriate to the age and maturity level of the youngster such as curfews, chores, school and homework rules, and dating rules; and providing and expressing emotional support, nurturance, and caring (Barnes, 1980). Typically, treatment parents also maintain close contact with the schools and other community agencies that are involved with the child and may become involved in a supportive and facilitative relationship with the natural parents. The expanded and varied role of treatment parents has led most programs to reject the term "foster parents" with its more limited and traditional connotations, and to adopt terms such as "treatment parents," "parent counselors," "professional parents" and the like which are considered more descriptive of therapeutic foster care. Similarly, because of the prominent role these individuals play, programs have attempted to systematically increase the status of treatment parents, regarding them as professional colleagues and providing them with the training, support, recognition, and payment that should be associated with such professional status.

The characteristics of treatment parents vary widely both within and among programs. In fact, there is no agreed upon set of "preferred" demographic characteristics for treatment parents. Programs have reported success with two-parent families, one-parent families of both sexes, and families with a wide range of social, economic, and ethnic backgrounds.

Programs responding to the Snodgrass and Bryant (1989) survey reported that the age of treatment parents ranges from the 20s to the 70s, with the average age falling between 30 and 45. This is substantiated by data from PRYDE, People Places, and Professional Parenting indicating that the average age of treatment parents is from 37 to the mid-40s (Gross & Campbell, 1989). Most treatment parents are married, with the majority having been married for substantial periods of time (more than 10 years) prior to becoming treatment parents. The majority of treatment parents have biological children of their own (Bauer & Heinke, 1976; Friedman, 1981; Gross & Campbell, 1989). For example, younger treatment parents may have preschool children and the mother is interested in a career opportunity at home; older couples may have children who are no longer living within the household.

The socioeconomic status (SES) of treatment parents is highly variable; some treatment families may have been on AFDC while others are upper middle class families with incomes in excess of $50,000 (Snodgrass & Bryant, 1989). Programs appear to have differing biases with respect to the SES levels of treatment parents. For example, some programs may recruit lower and lower middle class treatment parents since their backgrounds and lifestyles are more similar to their client population and, therefore, may provide a more comfortable environment for youngsters. Other programs have matched lower SES youngsters with middle class treatment parents without apparent difficulty. The racial and ethnic characteristics of treatment parents also vary widely, generally depending upon the ethnic composition of the particular geographic area. Some programs have found that training materials and curricula needed some revision and adaptation in order to meet the needs of minority treatment parents (Engel, 1983).

With respect to employment, many programs prefer that one treatment parent not be employed outside the home and remain available for treatment parenting on a full-time basis. While this is most desirable, programs often cannot afford the luxury of limiting treatment families to couples in which only one parent works outside the home. As an alternative, couples with flexible schedules are sought who can be accessible during the day for routine responsibilities as well as crises (Meadowcroft, 1988). The jobs of treatment parents are diverse, spanning professional, technical, and labor occupations. Some programs target individuals who ordinarily would have to work outside the home, but for whom treatment parenting offers the option of employment within the home.

Most treatment parents are well educated and have completed at least high school and, in many cases, education beyond high school. In the survey conducted by Snodgrass and Bryant (1989) 52 percent of the programs reported that the average educational level of treatment parents is completion of high school; an additional 35 percent of the programs reported the average educational level as high school plus some college or advanced training. In a review of the Florida programs, Friedman (1981) reported that the majority of the treatment parents had more than a high school education, and two-thirds of PRYDE's treatment parents have education beyond high school as well (Gross & Campbell, 1989).

Some programs require treatment parents to have educational backgrounds in human service fields and considerable previous experience in working with troubled youngsters. For example, the Northeastern Family Institute's Professional Parent Homes Program (Burlington, Vermont) recruits education and human service professionals to serve as treatment parents, and the San Francisco Therapeutic Homes Program requires the primary treatment parent to have college level training in a mental health field and at least one year of paid experience working with disturbed children. The Washington County Professional Foster Care Program in Vermont recruits treatment parents with graduate degrees in a human service field, and treatment parents have an average of more than eight years' experience in related fields (Welkowitz, 1987). The rationale for such prerequisites is that the problems presented by children in therapeutic foster care are too severe and challenging to be handled effectively by less educated and less experienced individuals.

While some programs may recruit treatment parents with college degrees and paid experience, others are equally adamant that formal credentials are not necessary. These programs contend that good basic parenting skills along with sincere desire and commitment are the key ingredients and that the skills and techniques needed for treatment parenting can be learned through the preservice and inservice training processes. With respect to previous foster care experience, some programs have found that recruiting seasoned regular foster parents is an advantage since treatment parents who have already experienced some of the stresses that are involved in foster parenting are more cognizant of what they are undertaking. Other programs tend to avoid recruiting existing foster parents based on the assumption that therapeutic foster care is qualitatively different and that it may be better to recruit individuals who are not tied to old roles and relationships. Only 10 percent of PRYDE's treatment parents were regular foster parents prior to becoming treatment parents (Meadowcroft, 1988).

While the demographics may vary, there appears to be more commonality across programs in some of the personal characteristics of treatment parents (Chamberlain, 1988; Goldstein, Gabay, & Switzer, 1981; Rice & Semmelroth, 1968; Roe, 1988). Some of the qualities shared by many treatment parents include the following:

o Treatment parents have good parenting skills and successful experiences living with and understanding "normal" child development.

o They generally are stable, well-adjusted, emotionally mature, and highly functioning individuals who handle stress well and who are part of stable, healthy families.

o They tend to be active, involved individuals whose lives are already full of satisfying people and events.

o They have histories of contributing to the community and of being involved with schools, churches, community groups, and other social institutions.

- They demonstrate high levels of affection, understanding, and sensitivity toward children and high levels of flexibility, acceptance, tolerance, and patience with difficult and disturbed behavior.

- They are committed individuals who are challenged by the task of helping severely disturbed youngsters and demonstrate a sincere desire to do so.

- They are willing and capable of functioning as a member of a treatment team which includes professionals and natural parents.

Programs emphasized that most treatment parents see themselves as professionals. They are attracted to the job of treatment parenting not to fill unmet needs in their lives but because it offers a challenge that is appropriate to their abilities. An important attribute of treatment families is that all members of the household are enthusiastic about participating in the program. In two-parent families, the role of the treatment father is particularly important, and treatment parenting is most successful when both spouses are closely involved in operating the treatment home and implementing the treatment program (Bauer & Heinke, 1976).

While data are limited, there have been some attempts to compare the characteristics of regular foster parents and those of specialized foster parents (i.e., treatment parents) who serve children with emotional problems and other handicaps. A study comparing regular and specialized foster parents found that they came from similar demographic backgrounds, but that, on average, specialized foster parents were younger, more highly educated, and had more significant training in child development prior to becoming a foster parent. Further, specialized foster parents were more likely to cite "job-oriented" factors (such as income or satisfaction from helping a child to improve) as their primary motivation whereas regular foster parents were more likely to cite emotional, altruistic, or family-based motives such as warmth for children (Hampson, 1975). These findings have clear implications for recruitment of treatment parents in that recruitment efforts should focus more heavily on the professional challenges and rewards of treatment parenting rather than on the altruistic and parenting aspects (Hampson, 1988).

Recruitment and Selection

There can be no disputing the fact that successful recruitment of capable treatment parents is the key to establishing and maintaining an effective therapeutic foster care program. However, recruitment has been characterized as the most formidable obstacle facing programs. According to Gross and Campbell (1989), recruitment is an extremely difficult task, and strategies used to recruit regular foster parents often are ineffective in producing treatment parents to work with seriously disturbed youngsters. Particularly in rural areas, programs may face continuing struggles to attract and maintain pools of qualified treatment parents who are willing to cope with the difficult and complex problems manifested by children in therapeutic foster care. Recruitment is an even greater problem for programs that encourage long-term placement in treatment homes and, as a result, are required to "replace" treatment slots lost to ongoing care (Beggs, 1987). Programs also report considerable difficulty in recruiting treatment parents to work with adolescents; most are more comfortable serving younger children and may be less confident in their abilities to cope with the problems of adolescents (Gross & Campbell, 1989).

Despite these difficulties, many therapeutic foster care programs report considerable success in locating treatment families. Barnes (1980) challenged the notion that there are few potential treatment parents, calling this a myth. She asserted that most communities are full of potential treatment parents who must be reached through creative recruitment efforts. The task of recruitment is to make people aware that they have something valuable to offer troubled children by becoming treatment parents. Similarly, Meadowcroft (1988) stated that there is no reason to believe that treatment parents are a scarce resource. According to Meadowcroft, difficulties in maintaining a sufficient pool of treatment parents do not result from a lack of interest within the community but rather from failure to devote sufficient energies to recruitment, failure to target the appropriate population in recruitment efforts, or failure to provide sufficient pay to attract treatment parents.

Programs that are successful in recruiting a constant supply of treatment parents are those which consider recruitment to be an integral and ongoing function of program operations. In these programs, recruitment activities are continual although there may be intensified periods of recruitment activities during certain times of the year. Further, these programs devote sufficient staff resources to ensure that recruitment activities are not neglected due to competing service delivery priorities. To this end, some programs utilize full-time staff persons to conduct and manage recruitment efforts; others delegate recruitment responsibilities to several staff persons who may have other responsibilities. PRYDE assigns staff to fulfill the recruitment function but also considers every staff person and treatment parent to be a part of the recruitment team responsible for targeting his or her own personal network (Grealish, Hunt, James, & Lynch, 1987).

After ensuring that sufficient staff resources are devoted to recruitment, the next step involves identifying the target audience for recruitment activities. This planning task involves determining the nature of client to be served, the kinds of families that might best serve this client population, and how these types of families might best be reached (Gross & Campbell, 1989; North Carolina Department of Human Resources, 1987). Once the characteristics of desired treatment parents can be described (e.g. age, interests, types of occupations, organizational affiliations, and educational backgrounds), it is easier to select recruitment strategies that are most likely to reach the target audience. For example, the Lee Mental Health Center focuses recruitment efforts on persons with altruistic motivations and has experienced considerable success in approaching priests, ministers, and rabbis and enlisting their help in identifying potential treatment parents from within their congregations. School employees and service clubs have also proven to be a fruitful source of treatment parents. Thus, recruitment campaigns must be designed to reach and attract the types of persons that would make the most appropriate treatment parents for each program.

As noted, continuous recruitment efforts are needed in order to keep pace with demand, allow for program growth, and replace parents who leave the program. Gross and Campbell (1989) emphasized that sporadic recruitment is not productive and recommended that recruitment activities be ongoing with intensified periods of recruitment activities at certain times during the year. Fall and spring are considered ideal times for intensive recruitment campaigns; recruitment efforts during summer and winter holiday seasons are less likely to generate as much interest and response. Intensive recruitment campaigns generally last from two to four weeks and involve a multi-media "blitz" as well as a variety of presentations and personal contacts. All of these activities may occur at a reduced level of effort throughout the rest of the year. The strategies used for recruitment, both on an ongoing basis and during intensive recruitment campaigns, include:

o Advertisements in various media, both paid and public service advertisements, including newspapers (sometimes in sports section), radio, and television.

o Feature stories and interviews about the program in newspapers, radio, and television.

o Appearances on television and radio talk shows.

- Presentations to particular target audiences such as churches, schools, service organizations, PTAs, and family-oriented organizations.

- Recruitment booths at malls, state fairs, and local festivals with attractions such as coloring contests, video camera and monitor to attract children, and balloons with agency name and number.

- Direct mail campaigns involving mass mailings of letters, flyers, or brochures to school employees, churches, colleges, universities, large employers, and community organizations.

- Home recruitment parties (patterned after Tupperware parties), often held at the homes of current treatment parents, with informational presentations and refreshments.

- Posters, billboards, and brochures at places that are likely to be frequented by the target audience such as local restaurants, laundromats, medical clinics, cleaners, grocery stores, movie theaters, bowling alleys, and unemployment agencies.

- Contacts with community leaders.

- Finder's fee for treatment parents and agency staff for each trainee recruited.

Programs indicate that it is advisable to use as many strategies as possible within budget constraints in order to maximize exposure, particularly during intensive recruitment campaigns. Such recruitment efforts are likely to produce a substantial number of responses, although a large percentage of the respondents may ultimately prove to be inappropriate candidates for treatment parenting (Knickerbocker & Langford, 1978).

By far the most effective recruitment strategy reported by programs is word-of-mouth, the personal networking activities of both existing treatment parents and staff. Treatment parents, by virtue of their commitment and enthusiasm, generally experience much success in recruiting their friends and relatives. Approximately 60 percent of PRYDE's treatment parents are recruited by current treatment parents, using methods such as home recruitment parties whereby treatment parents host informational gatherings in their homes and invite potential treatment families. An additional 34 percent of PRYDE's treatment parents are recruited through other, less formal, word-of-mouth methods; only 6 percent of all treatment parents are recruited through media exposure and mailings (Hawkins, Meadowcroft, Trout, & Luster, 1985). At People Places, approximately 50 percent of the treatment parents are recruited by other teaching parents or staff (Bryant, 1980a; 1981).

Of the programs included in Snodgrass and Bryant's (1989) survey, 93 percent indicated that word-of-mouth is a useful recruiting method; 69 percent cited this as the single most productive recruitment strategy. Gross and Campbell (1989) concluded that person-to-person recruiting activities produce excellent results with respect to both the number and quality of recruits. Many programs attempt to encourage word-of-mouth recruitment by offering incentives. Most frequently, incentives involve a finder's fee of approximately $100 for any staff member or treatment parents who successfully recruits a new treatment family.

The importance of personal networking as a recruitment strategy was demonstrated in a survey of foster parents of retarded children (Coyne, 1978). While mass media campaigns were found to increase awareness of the foster care program, personal contact, especially with current or former foster parents, appeared to be the decisive factor in the decision to apply to become foster parents. These findings suggest that using foster parents to recruit other foster parents may well be the most effective recruitment method and provide a strong rationale for involving treatment parents in home finding.

Of course, new programs are without the resource of existing treatment parents to aid in recruitment and must, of necessity, rely solely on media, mailings, presentations to groups, and the like. Additionally, the quality of the first group of treatment families can have profound implications for a new program's future success (Gross & Campbell, 1989; Hawkins, Meadowcroft, Trout, & Luster, 1985; Meadowcroft & Luster, 1989; Snodgrass & Bryant, 1989; Welkowitz, 1987). Because of the effectiveness of word-of-mouth recruitment, future treatment parents often are friends, relatives, and acquaintances of current treatment parents. Thus, the calibre of the initial group of treatment parents can impact the types of people who are likely to become involved with the program subsequently. Meadowcroft and Luster (1989) emphasized that the initial ability to recruit a core of excellent treatment parents is a major determinant of the program's future success.

The recruitment message must be designed to attract persons who are most likely to be interested and qualified to serve as treatment parents. As suggested by Hampson's (1975) study and others (Gross & Campbell, 1989), regular foster parents tend to be attracted by their love for children and sympathies for children who are neglected or abused. Treatment parents, however, generally are more attracted by the challenges of professional parenting and tend to perceive treatment parenting as a career opportunity. Accordingly, the recruitment message should emphasize the professional aspects of treatment parenting, the opportunity for growth and satisfaction, and the financial rewards along with a realistic picture of the difficulty of the task and the potential problems that are likely to be encountered (Grealish, Hunt, James, & Lynch, 1987). The North Carolina Department of Human Resources (1987) suggested that the recruitment message should focus on the challenge of the task; the professional aspects of the treatment role; the training and support provided by the program; the payment and benefits; the convenience of a career at home; some required qualities of treatment parents; some characteristics of the children needing placement; and a request for commitment (North Carolina Department of Human Resources, 1987). In its recruitment message, People Places emphasizes the professional opportunity offered by treatment parenting, the potential for a second income, and the chance to work closely with a team of professionals.

Immediate follow-up on all inquiries about the program is essential. Barnes (1980) stated that the program's initial response to interested persons is a crucial point in the recruitment process. Both the manner and timing of the program's response can be important. If there is a substantial lag time at various stages of the recruitment and selection process, applicants are more likely to lose interest (Gross & Campbell, 1989).

Throughout the recruitment process, attrition is a fact of life. It has been estimated that approximately 50 percent of the applicants are lost between the time of initial inquiry and the beginning of training, and an additional percentage is lost as training progresses (Snodgrass, 1977). This indicates that while recruitment procedures may result in a large number of inquiries, only a very small percentage (perhaps 8 to 12 percent) actually progress to the point of serving children within their homes. For example, for a six month period, PRYDE received 198 inquiries. Only 53 percent of these requested applications; 55 percent of this group actually returned their completed applications; 25 percent of these applicants were screened out and the remainder were scheduled for interviews; 80 percent of those interviewed were invited to begin preservice training; and 20 families completed training (10 percent of the initial pool). Ultimately, 12 of these families served children -- only 6 percent of the initial pool of interested persons (Meadowcroft, 1988). The typically high rate of attrition throughout recruitment, selection, and training underscores the importance of continuous recruitment activities to ensure the availability of sufficient treatment family resources.

Although recruitment efforts may succeed in identifying an array of interested individuals, many may not be appropriate candidates for treatment parenting. Programs use extensive screening and selection procedures designed to determine which candidates possess the appropriate mix of skills, personal characteristics and qualities, and family situation to become treatment parents. Early therapeutic foster care programs recognized the difficulty involved in evaluating families to determine their potential for caring for disturbed children (Maluccio, 1966; Mora, 1962). Selection procedures are needed to assess a family's ability to provide a healthy, therapeutic environment for a child as well as to assess the family's capacity to withstand the added stresses, pressures, and demands of caring for a disturbed child. Mora (1962) noted that programs cannot expect to find "perfect" families, devoid of all conflicts and problems. Rather, the goal of the selection process is to evaluate the strengths and weaknesses of prospective treatment families.

The selection process typically involves a series of interviews, with one or more of these interviews occurring in the family's home. Programs generally require both parents (and children in the household, if appropriate) to attend the initial interview which is largely informational in nature. Staff can begin to get a feel for the family while providing information about the program and treatment parenting. By the conclusion of this initial meeting, prospective treatment parents have sufficient information to determine whether or not they wish to pursue the process any further. Programs report that they are careful not to pressure candidates into making a decision at any stage of the process. Rather, staff tend to be brutally honest about the difficulties, problems, and stresses involved in treatment parenting as well as about the rewards.

If the individuals decide to proceed, the selection process continues with additional interviews, completion of a detailed application or questionnaire, check of personal and professional references, check of criminal records and child abuse records, and an assessment of the physical setting of the home. Psychiatric or psychological evaluations are part of the selection process in some programs. Thus, the selection process provides ample opportunity to consider the qualifications of treatment parents individually, as a couple, and as a complete family unit.

The selection of treatment parents is guided by a set of criteria, although the extent to which these criteria are formally articulated varies considerably across programs. Though infrequent, some programs require particular education and experience. For example, completion of high school may be a requirement for both treatment parents; the primary treatment parent may be required to have a bachelor's degree and/or experience in working with troubled children (Snodgrass & Bryant, 1989). Beyond these types of requirements, the selection criteria used by most programs can be grouped into three categories (Gross and Campbell, 1989; North Carolina Department of Human Resources, 1987):

- Parenting Skills and Learning Potential - A major aspect of the selection process involves attempting to evaluate the current level of the candidates' parenting attitudes and skills coupled with their willingness and motivation to learn new approaches and techniques for working with emotionally disturbed youngsters. Through interviews, interactions, observation with their own children, and written responses, staff attempt to determine parental philosophy and values, child rearing practices, discipline methods, ability to set realistic expectations, consistency in managing behaviors, listening and communication skills, problem solving skills, flexibility and tolerance, and so forth. Hampson (1988) noted that "parental causation" is an important screening criterion -- the degree to which parents see themselves as having a causal or influential role in child behavior. This is particularly important for treatment parents as they will be required to act as the therapist or behavioral change agent for the child. A critical aspect of assessing parenting skills involves examining the candidates' willingness and ability to learn and apply new parenting skills, their desire to participate in training, and their willingness to work under close staff supervision and accept frequent advice and technical assistance.

- Personal and Family Characteristics - During the screening process, programs collect a wealth of information about each prospective treatment parent and about the family as a whole. This includes information about things such as age, income, marital status and marital history, employment history, family size and ages of children, and physical and mental health history. Information also may be sought regarding driving records, police records, ownership of firearms, and use of alcohol or drugs. Family size and patterning of siblings in the household may be especially relevant to the selection process. Hampson (1988) cited research findings which suggested that families with greater numbers of children are less likely to meet the needs of handicapped foster children and, further, that sibling reactions to handicapped foster children are less problematic when the normal siblings are older.

  In addition, programs explore candidates' character and personality based upon interviews, observation, and the reports of others through reference checks. While hoping that any major problems will surface through the process, staff look for a host of desirable traits such as flexibility, tolerance for deviant behaviors, patience, persistence, high energy level, sensitivity, response to stress, and stability. The family's level of motivation and commitment also is considered, including their apparent willingness to devote time and energy to training, to work as part of a treatment team, to be involved with biological parents, to work with children of different ages and backgrounds, and, above all, their willingness to make a commitment to a youngster with special needs. The treatment father's motivation, in particular, is an important screening issue in two-parent families--the degree to which the father is willing to participate in training and in the treatment of the child (Hampson, 1988).

- Licensure Requirements - Each state has specific standards that must be met in order to qualify for licensure as foster parents. These standards may cover age and health status of the prospective foster parents as well as a host of standards related to the physical home environment such as sufficient size; adequate furnishings and equipment; adequate bathrooms, water, ventilation, heat, and cooking capabilities; and absence of fire and health hazards. The screening and selection process includes questions and home visits to ensure that prospective treatment parents are likely to meet these state standards.

  The licensing process itself is handled differently across states. In some states, the child welfare agency licenses all foster homes, regular or therapeutic. In others, other agencies (such as the mental health agency) may have the authority to conduct home studies, review required fire and health inspection reports, and license treatment homes. Some jointly funded programs have dual licenses from both the child welfare and mental health agency. In some cases, the program itself is empowered to conduct home studies and approve treatment homes for licensure. Programs which do not have this authority often complain that the bureaucratic process of licensing homes is fraught with time lags and delays of many months.

With considerations in each of these areas, the assessment of prospective treatment parents typically is exhaustive. In their experience evaluating and selecting potential treatment parents, programs have identified some characteristics which are "red flags" and would argue against selection for participation in training (Chamberlain, 1988; Parent Therapist Program, 1988). These include candidates who:

- Appear overly parental or smothering;
- Believe that "love can cure all";

- Want to rescue a child;
- Appear motivated most by the money;
- Are ultra-religious;
- Disagree strongly with elements or philosophy of the program;
- Insist on physical methods of discipline;
- Are uncomfortable with close monitoring and supervision;
- Feel their main goal is to instill their particular moral or religious values; and
- Appear to have one interested spouse and one unmotivated spouse.

With this extensive information-gathering process, staff are provided with a great deal a data for decision making. In many programs, several staff members are involved in interviewing and reviewing information about prospective treatment parents, and decisions regarding acceptance for training are made as a group. Throughout the recruitment and selection process, candidates also are likely to assess their own suitability for treatment parenting. As they learn more about the demands of treatment parenting, the types of children involved, and the program requirements, they may realize that they are not prepared to make the commitment and may withdraw from further consideration. Gross and Campbell (1989) stated that this type of self-selection should be encouraged since it offers a comfortable way of eliminating families who are unlikely to persist through difficult problems and challenges.

Training

All therapeutic foster care programs require treatment parents to participate in some combination of preservice and inservice training. While the approach, breadth, duration, and content of the training varies from program to program, the importance of training is not disputed. In therapeutic foster care, treatment parents represent the "front line" (Bryant, 1980b). Supervision, consultation, and support are provided by professionals, but treatment parents are the critical members of the treatment team, working directly with the child on a day-to-day basis. In order to do their job effectively, treatment parents must be equipped with the knowledge and intervention skills needed to work with emotionally disturbed youngsters. Early experience in therapeutic foster care demonstrated that foster homes cannot be labeled as treatment homes as an afterthought simply because a severely disturbed child is in placement; the absence of sufficient training for treatment parents to work with special needs youngsters severely restricts the potential effectiveness of the program (Bauer & Heinke, 1976). Even if they have vast parenting experience, it cannot be assumed that treatment parents possess the skills needed to be successful in a therapeutic program with seriously disturbed youngsters.

The results of several studies support the importance of training for treatment parents. Ambinder and Sargent (1965) reported the results of a study of techniques used by experienced regular foster parents in dealing with problem behaviors. They found that 73 percent of the techniques used by foster parents with a population of emotionally disturbed boys were either harmful or not helpful (e.g., threats, removing children from the home, physical punishment, or ridicule). In many cases, the parents recognized that their techniques were not effective but had no knowledge of alternative approaches for responding to the disturbing behavior. The researchers concluded that much training is needed to broaden treatment parents' understanding of how their behavior influences emotionally disturbed children and to equip them with a wide assortment of treatment techniques to increase their effectiveness.

An evaluation of parental attitudes and skills was conducted to compare a sample of People Places treatment parents with a sample of untrained foster parents providing regular foster care services (Bryant, 1980a; 1981). The People Places treatment parents, who had completed extensive preservice and inservice training, scored higher than the regular foster parents in both knowledge and use of effective parenting techniques. Further, they considered themselves causal agents in influencing children to a greater extent and they perceived their role more in terms of active, goal-oriented tasks rather than as simple care-taking. Another study documented that training reduced unsuccessful placements, increased the probability of desired outcomes, and increased the retention of foster parents in the program (Eastman, 1982).

The training provided by therapeutic foster care programs serves multiple purposes. Most programs emphasize that training is a natural continuation of the selection process (Hampson, 1988; Meadowcroft & Grealish, 1989). Throughout the preservice training process, potential treatment parents have the opportunity to assess whether they have the time, energy, commitment, and aptitude to actually work with a troubled child in their home. Based upon their increased knowledge about the types of problems they will be facing and the requisite skills, treatment parents may decide to withdraw from the program and avoid disappointment and failure in the future. Training also provides staff with a vantage point for observing the performance of prospective treatment parents and for evaluating their strengths, weaknesses, and motivation. In appropriate circumstances, treatment parents may be screened out at any point during the training program. The PRYDE Program expects approximately 40 to 50 percent of a training class to complete the training program; the remainder either withdraw or are screened out.

Beyond screening, training is designed to increase treatment parents' knowledge and understanding of problem behavior and to refine parenting and intervention skills. Preservice training often is seen as providing a foundation -- the fundamentals of client care and therapeutic procedures. Inservice training, which is provided throughout participation in the program, continues the training process and enhances knowledge and skill development on an ongoing basis (Hampson, 1988). A third major purpose of training is to prepare treatment parents for some of the difficulties they are likely to face in their work with troubled children, such as the types of behaviors they may encounter or potential rejection from a child. Treatment parents have reported that no training can totally prepare them for the actual experience, but that it is helpful to have some prior knowledge and expectations of the nature and severity of the problems that the youngsters are likely to manifest.

The design of preservice training varies widely among programs. The survey conducted by Snodgrass and Bryant (1989) found that the number of preservice training sessions required by programs ranges from 1 to 14, with an average of about 6 sessions. The total number of hours of preservice training varies as well. The three programs described by Meadowcroft and Grealish (1989) require 16 hours (Professional Parenting), 18 hours (People Places), and 25 hours (PRYDE). The Alberta Parent Counselors Program requires each treatment parent to participate in as much as 35 to 40 hours of formal preservice training (Bryant, 1980a; 1981).

Training sessions generally are held during evening and weekend hours when it is most convenient for trainees to attend. Many programs require that, in two-parent families, both spouses attend the training program. In some cases, incentive payments are provided to treatment parent couples for each session attended. The size of training classes ranges from approximately four to eight couples in order to ensure a manageable group for the more experiential aspects of the training. Staff persons of the program generally serve as trainers, often with a team of two trainers assigned to each class. Some programs assign a treatment parent to work with the trainers which adds the dimension and perspective of direct experience to the curriculum (Meadowcroft & Grealish, 1989).

The training curricula designed for treatment parents usually combine didactic approaches, involving presentation of information to participants, with experiential approaches, involving learning and practicing specific skills. The Snodgrass and Bryant survey (1989) revealed that 56 percent of the respondent programs characterized their training as more knowledge-oriented with an emphasis on presentation of information; 44 percent of the programs characterized their curricula as more skill-oriented with an emphasis on mastering behavior management and communication skills. The respondent programs serving emotionally and behaviorally disturbed children were more likely to rely on skill-based training curricula.

There is powerful evidence of the value of skill-based approaches to the training of treatment parents. Bryant (1980b) stated that while didactic approaches may be useful for general orientation, practice-oriented approaches are needed to help treatment parents learn specific intervention and management techniques. He emphasized that merely explaining therapeutic techniques to trainees does not usually influence the use of these techniques. Rather, treatment parents are more likely to use techniques that they have learned and practiced with approaches such as modeling, role playing, feedback, and reinforcement. Daly (1989) also noted the importance of skill-based training, asserting that the most effective approach is a "program specific skills approach" which goes beyond conceptual knowledge and emphasizes the development of specific skills. Since skills comprise the majority of the treatment behavior expected of treatment parents, programs should teach them what to **do** in performing their role and not just **about** performing their job. Thus, it is recommended that a significant portion of the training be devoted to observing specific skills being modeled (live or on videotape), actually practicing skills, and providing feedback in addition to lectures and reading. This behavior rehearsal approach allows both trainers and trainees to readily assess the degree of mastery of specific skills and to devote additional effort to skills that prove more difficult for an individual trainee.

The content of training tends to be tailored to the specific philosophy and treatment approach of each program, although there is significant overlap of subject areas across programs (Meadowcroft & Grealish, 1989; Webb, 1988). Programs generally cover:

o An orientation to the program and philosophy and goals of therapeutic foster care;
o Understanding emotional disturbance and reviewing behavioral, social, and emotional problems commonly exhibited by the children served by the program;
o Communication skills;
o Behavior management principles and techniques such as analyzing behavior, and using positive reinforcement and point systems;
o Discipline and handling difficult behaviors with techniques including instruction, modeling, feedback, time out, limit setting, natural and logical consequences, problem solving, and negotiation;
o Building a positive relationship with the child;
o Stress management;
o Handling crises often including self-defense and passive physical restraint as well as emergency procedures and emergency first aid;
o Working with natural families; and
o Helping the newly placed child to adjust.

Some portion of the training also is devoted to specific program procedures including record-keeping and reporting requirements. Specialized training content may be added to the curriculum to meet specific program needs. For example, Kaleidoscope adds eight additional weeks of training for treatment parents who will work with adolescent parents and additional training for treatment parents who will work with children with AIDS. Some programs add content to prepare treatment parents to teach independent living skills to adolescents (Teaching Research, 1986).

Some programs have pre-established criteria to assess trainees' performance (Meadowcroft & Grealish, 1989). Criteria may include attendance, completion of homework, and criterion-based mastery of treatment skills as well as the more subjective evaluations of trainers. Trainees who meet the specified criteria are "certified" as treatment parents at the completion of the preservice training.

Some therapeutic foster care programs develop their own training program and curriculum. Others purchase training programs from other therapeutic foster care programs and then customize the design and content to their own particular program and community. Complete preservice training packages may be purchased such as the Parenting Skills Training package which is available from People Places (Bryant, Snodgrass, Houff, Kidd, & Campbell, 1986). This package includes a scripted trainer's manual; participant manuals with work sheets, case study materials, and narratives; and videotaped skill models and audiotapes to assist trainers. The training program is competency-based and focuses on a set of core skills considered essential to working with disturbed children. New programs may find it efficient to contract with experienced trainers from existing programs to conduct the training of the initial group of treatment parents and, perhaps, staff. Additionally, these trainers may work with staff to prepare them to train subsequent classes of treatment parents (North Carolina Department of Human Resources, 1987).

While preservice training is critical, programs acknowledge that preservice training cannot ensure that treatment parents will have all the intervention skills needed to work with a particular child in their home (Meadowcroft & Grealish, 1989). Thus, most programs provide inservice training for treatment parents to continually enhance their skills and competence and to help them learn treatment strategies specific to the child in placement. Inservice training takes two forms. Inservice training workshops, often held monthly, provide a forum for teaching additional skills and reinforcing previously learned skills. Many programs require treatment parents to attend monthly inservice training sessions; some programs provide financial incentive payments for attending the workshops as well as babysitting and refreshments. For example, the PRYDE Program requires treatment parents to attend a minimum of 8 of the 10 sessions offered each year. Workshops may focus on a special topic such as substance abuse, sexual misconduct, or how to help youngsters make friends, or they may be devoted to sharing problems and potential intervention strategies among treatment parents. Some programs arrange for a consultant psychiatrist to attend inservice sessions for case presentations, clinical supervision, and treatment planning (Engel, 1983). A significant side benefit of the inservice sessions is the creation of a group identity and support system among treatment parents. The Lee Mental Health Center considers support to be one of the most important elements of the monthly inservice meetings.

The second type of inservice training is the individualized, case-specific training and consultation provided to treatment parents by program staff. While a lot can be accomplished in group training programs, treatment parents need practical, individualized training provided by skilled staff in the home (Bryant, 1980b; Hampson, 1988; Meadowcroft & Grealish, 1989; Snodgrass & Bryant, 1989; Welkowitz, 1987). The provision of individualized, in-home, case-specific training frequently is mentioned as one the most important elements of therapeutic foster care. As noted previously, staff visit treatment homes approximately weekly or more often if necessary. Much of the time spent with treatment families can be characterized as inservice training, involving providing information on issues that have arisen with the child in placement (e.g., substance abuse) or teaching new techniques to respond to the child's behavior. This "on-the-job" training model is reported to be particularly effective with treatment parents, as it may be easier to learn and apply a strategy to a real and current situation.

Supervision and Support

Most supervision of treatment parents is provided by the staff who visit the treatment home regularly to offer inservice training, consultation, and support. Some programs also utilize a group structure to provide supervision. For example, for each group of treatment parents the Parent Therapist Program in Ontario arranges weekly meetings with a senior program staff person. The meetings are used for supervision as well as for training and mutual support purposes (Gold Award, 1977).

Regardless of the mechanism for supervising the performance of treatment parents, most programs have some procedure in place for periodically evaluating treatment parent performance. Sixty-eight percent of the programs responding to the Snodgrass and Bryant (1989) survey reported that they regularly evaluate the performance of treatment parents. Some programs employ well-defined and formal procedures for treatment parent evaluation. The Professional Parenting Program employs a "Professional Parent Performance Assessment Sheet" which is completed weekly by staff and includes an assessment of the couple's tolerance for difficult behavior, willingness to implement feedback, and an estimate of overall performance (Jones, 1989). People Places staff complete a parent rating scale every six months which assesses 12 critical treatment parent behaviors; PRYDE uses a parent evaluator to observe treatment parents in the home after the first six months of service, after the first year, and annually thereafter (Meadowcroft & Grealish, 1989). The PRYDE Program ties financial incentive to performance evaluation, with per diem increases of up to $2 available depending upon the ratings. Treatment parents demonstrating marginal performance may be placed on probationary status and required to show an improvement in three months or risk termination from the program.

Daly (1989) reported that the evaluation of Boys Town Family Teachers, similar to the approach used by PRYDE, also includes a consumer satisfaction component in which children evaluate their satisfaction with treatment parents as well as an assessment of program effectiveness -- the extent to which the environment and interventions provided by the treatment parents were successful in producing actual positive behavior changes in the child.

The extent and quality of support for treatment parents is a critical factor in retaining them in the program. The risk of burnout and frustration among treatment parents is high, and burnout tends to occur most often when treatment parents cannot find resources to assist them with their problems (Teaching Research, 1986). One of the early therapeutic foster care programs found that "periodically, these patient, forbearing people seem to reach the limits of their endurance, and then the agency must immediately respond to their call for help, bolster their ego, and encourage their efforts so that with renewed vigor they can return to the task of helping the children who need them" (Fine, 1966). As emphasized by Barnes (1980), experienced treatment parents who are committed to caring for troubled youngsters are a commodity that is difficult to replace. Thus, it is incumbent upon the program to provide extensive supports and rewards to treatment parents to maximize their comfort and satisfaction in their role.

As described previously, programs provide a variety of support services to treatment homes including frequent and intensive staff consultation, respite services, 24-hour crisis intervention, parent aides, and the like. Beyond these services, other forms of support are provided to treatment parents to minimize burnout and reinforce their efforts. One approach used by programs is to provide special recognition to treatment parents to let them know that they are providing a valuable service and that they are appreciated. Programs have a variety of creative mechanisms for recognizing treatment parents and for rewarding their competence and accomplishments (Meadowcroft & Grealish, 1989). These include:

- Dinners or luncheons such as the Kaleidoscope annual foster parents awards dinner during which all foster parents receive certificates of merit and special awards are presented;
- Mention in the agency-wide newsletter of especially creative or effective strategies used by treatment parents to work with a disturbed child;

- Social events for treatment parents and staff;
- Tee-shirts for treatment parents;
- Special letters for a job done particularly well;
- Greeting cards sent to treatment parents on special occasions; and
- Designation of outstanding parents as "Master Treatment Parents."

These and similar efforts serve to reward and support treatment parents in performing a job that may not always be intrinsically rewarding. Another source of support and reinforcement for treatment parents is identifying with the agency and being part of a professional team (Friedman & Zeigler, 1979). Many programs attempt to provide for treatment parents a variety of professional opportunities which tend to be both reinforcing and motivating. Meadowcroft and Grealish (1989) reviewed some of these strategies, including inviting treatment parents to serve as training assistants; hiring treatment parents as parent supervisors and parent evaluators; helping parents to receive college credit for completing training and serving children; inviting highly regarded treatment parents to serve on an advisory board to the program; and encouraging treatment parents to present their experiences at local and national meetings.

By far the most commonly used source of support comes from treatment parents themselves. Many programs encourage the formation of groups or networks of treatment parents that provide emotional and social support for members. Treatment parent groups may meet at monthly inservice training sessions or perhaps more frequently. Regardless of the scheduling or formality of the meetings, the group context allows treatment parents to provide mutual support to one another, to engage in group problem solving around particularly difficult problems, and to reinforce and reaffirm each other's efforts as treatment parents. The power of the group in providing support to treatment parents should not be overlooked. Treatment parents reported that only other treatment parents truly understand the challenges and difficulties they face. Thus, groups of treatment parents, following a self-help model, are able to provide social and emotional support as well as practical help .

Programs report that, through the more formal group meetings and activities of treatment parents, more informal groups and networks of treatment parents often develop. These are comprised of treatment families that are naturally drawn to each other and become friends and resources for each other. Informal groups of treatment parents may get together for dinners, picnics, and other recreational activities and may provide respite and relief for each other.

For some programs, the grouping of treatment parents is an integral part of the program design (Gold Award, 1977; Levin, Rubenstein, & Streiner, 1976; Rubenstein, Armentrout, Levin, & Herald, 1978). The Parent Therapist Program in Ontario, for example, is based upon the "cluster" concept whereby groups of five parent therapist couples are organized into a group and function as a treatment team. The groups are intended to simulate naturally occurring extended families and members share responsibility for all children within the cluster. Children consider the other treatment parents in the cluster to be "aunts and uncles" and are in frequent contact with the adults and children within the cluster. This allows treatment parents to provide babysitting and respite for each other in homes that are competent as well as familiar and comfortable for the youngsters. Some programs include one couple within each cluster who does not have a child in full-time placement and remains available as a "relief couple" to provide respite and emergency assistance. The rationale for the cluster system is that the supportive working relationships which develop among treatment parents provide many valuable resources to assist treatment parents in solving problems and handling difficulties.

The Parent Counselor Program of the Children's Service Center in Wilkes Barre, Pennsylvania, and the Parent Therapist Program of Youth Residential Services in Akron, Ohio, both utilize the cluster concept. Clusters generally meet weekly with a staff person attending the meetings and serving as a facilitator and resource person. Confidentiality extends to the entire cluster so that information can be shared freely regarding the children placed in each home. These programs report that each cluster tends to have a different "personality" and that the group does not immediately relate as extended family. Rather, there are stages of development of the cluster group, and, during the early developmental phases, groups tend to be more dependent upon staff input. As the cluster matures, there is less reliance on the facilitator and more reliance on peers for problem solving, advice, and support.

Treatment parents from some programs have formalized their groups by organizing associations. For example, in 1986 Kaleidoscope's treatment parents formed the Kaleidoscope Foster Parents Association which is a member of the Illinois Foster Parents Association. The Association has its own by-laws and policy board and engages in a number of activities to benefit the treatment parents and the children. Activities include fund raising events, the proceeds of which go into a school fund for educational and vocational needs of children that the state cannot meet. The Association provides health insurance coverage for the Kaleidoscope treatment parents as a group, with premiums deducted from the treatment parent payments, and helps to orient new treatment parents by participating in training as well as by organizing a buddy system for new treatment parents.

Retaining qualified and experienced treatment parents is an important challenge for most programs. Treatment parents are the most important resource for a program, and it requires a tremendous investment of time and energy to recruit, train, and supervise them. Despite the difficulties and frustrations of treatment parenting, most programs report lower rates of attrition than might be expected (Friedman, 1980; Levin, Rubenstein, & Streiner, 1976). Meadowcroft and Grealish (1989) indicated that programs should anticipate a loss of approximately 30 percent of their treatment parents over a five year period and that treatment parents generally do not remain active for as long as regular foster parents. In the PRYDE Program, for instance, 6 percent of treatment parents move out of the area; 10 percent are terminated; and 12 percent burn out. The Lee Mental Health Center reported an attrition rate of 25 percent over ten years of program operation, although some of the loss of treatment parents can be attributed to the adoption of children in placement. The average length of service for PRYDE parents is approximately 18 months as compared with 21 months for Professional Parenting and 48 months for People Places (Gross & Campbell, 1989). During 1988-89, PRYDE Pittsburgh reported the average length of service of treatment parents to be 30 months, with a wide range of 10 to 77 months.

Payment

Payment for services provided by treatment parents is handled differently by different agencies. Some agencies, such as the Smokey Mountain Mental Health Center in North Carolina, arrange payment by having one of the treatment parents become an employee of the agency. This approach may obligate the agency to provide certain benefits to treatment parents (such as health insurance and paid vacation) and may require a concomitant reduction in payment. More frequently, treatment parents are considered be self-employed and are under contract to the therapeutic foster care program. The latter approach generally does not entitle treatment parents to the benefits provided to agency employees, but provides a less ambiguous status for income tax purposes. Sample contracts between the agency and treatment parents can be found in a manual on therapeutic foster care developed by the North Carolina Department of Human Resources (1987).

Foster care payments are fully deductible expenses on the income tax returns of treatment parents. Further, the Internal Revenue Service allows treatment parents to deduct "difficulty of care" payments which are the additional payments provided for serving physically, mentally, or emotionally handicapped children. Thus, the income provided by treatment parenting is tax free income.

Programs generally pay a daily or monthly rate to treatment parents. This payment is comprised of two portions: the room and board rate provided for regular foster care and the additional payment for providing therapeutic services. In some cases, these portions of the treatment parent payment come from two different sources, the social services agency providing the room and board payment and the program providing the differential.

Snodgrass and Bryant (1989), in the survey of programs, found that the total rates paid to treatment parents vary widely among programs. In their respondent programs, payments ranged from a low of $185 per month to a high of $1450 per month per child; the average payment across the sample of programs was $516.61 per month. They attributed the variation to differences in local income levels, market conditions, and funding resources. In some programs, the evaluation of treatment parents' performance and the level of their experience also can impact their rates of payment.

Programs at the higher end of the payment spectrum indicate that the primary treatment parent generally is required to give up employment outside the home and to care full-time for a difficult, demanding child (Beggs, 1987; Hazel, 1982). Thus, the payment should approximate a full-time salary for a comparable professional job. Programs at the lower end of the spectrum indicate that low payments are a major hindrance to their recruitment efforts and that reasonable payments must be provided in order to attract and retain competent treatment parents.

The chart on the following pages summarizes the **total** monthly payments provided to treatment parents by a variety of programs based upon published information. In addition to these monthly payments, many programs provide additional payments for a range of "extras." These may include:

- Payments for items such as smoke detectors, clothing, some recreational activities, babysitting and respite expenses, and any excessive travel or telephone expenses;
- Reimbursement to cover any damage caused by a child in placement;
- Stipends for participating in preservice and inservice training sessions; and
- Educational allowances to allow treatment parents to attend national conferences or training workshops.

Additionally, some programs pay a "vacancy rate" to treatment parents. For example, the Parent Counselor Program in Wilkes Barre, Pennsylvania, pays a vacancy rate of $3 per day for a period of up to 90 days when a treatment family has an empty bed.

RESOURCES

There is significant variability in the reported costs of therapeutic foster care. In large part, the variation in costs is attributable to the wide disparity in the level of payments made to treatment parents. It is estimated that more than half of the cost of therapeutic foster care services represents treatment parent payments (Snodgrass & Bryant, 1989). Costs for therapeutic foster care are reported to range between $35 and $150 per day per child (Meadowcroft & Luster, 1989). It is, however, difficult to determine and compare the costs of services across programs due to differences in accounting and costing methodologies. In addition, costs for special education, day treatment, therapy, and other adjunct services generally are not included in the formulas for computing the costs of therapeutic foster care. Further, programs compute and report their costs for different time periods, with programs reporting costs per child per day, per month, per year, or per episode of treatment. The data

TREATMENT PARENT PAYMENTS

Program	Monthly Payment	Reference
Alberta Parent Counselor Program	$700	Larson et al., 1978
Future Families Aptos, CA	$600	Beggs, 1987
Futures Unlimited St. Johnsbury, VT	$732	Welkowitz, 1987
Kaleidoscope Therapeutic Family Homes Program Chicago, IL	$1129	Program Materials
Lee Mental Health Center Fort Myers, FL	$460 for therapeutic foster care $1500 for individual residential treatment (IRT)	Site Visit
Love, Inc. Vergennes, VT	$330 per child	Welkowitz, 1987
Maryland Specialized Foster Care Demonstration Programs	$892 - $1292	Maryland Dept. of Human Resources, 1987
North Carolina Therapeutic Foster Care Programs - Willie M. Program	Average $1075 for special foster care Average $1610 for therapeutic foster care	North Carolina Dept. of Human Resources, 1987
Northeastern Family Institute Professional Parenting Program Burlington, VT	$1000 for one child $1500 for two children	Welkowitz, 1987
Parent Counselor Program Children's Service Center Wilkes Barre, PA	$480	Program Materials
Parent Therapist Program Ontario, Canada	$525 - $542	Levin et al., 1976
PATH Minneapolis, MN	$720	Program Materials

TREATMENT PARENT PAYMENTS, CONTINUED

People Places Staunton, VA	$500 - $600	Meadowcroft & Grealish, 1989
Professinal Parenting Morganton, NC	$400 - $900	Meadowcroft & Grealish, 1989
PRYDE Pittsburgh, PA	$650 - $810	Meadowcroft & Grealish, 1989
San Francisco Therapeutic Foster Homes Program San Francisco, CA	$1594 - $1640	Beggs, 1987
Upper Valley Youth Services Therapeutic Foster Care Program Lebanon, VT	$800	Welkowitz, 1987
Washington County Mental Health Professional Foster Care Program Barre, VT	$1100	Welkowitz, 1987

presented on the following pages provide examples of the costs reported for various therapeutic foster care programs.

Despite the considerable range in costs of therapeutic foster care, it appears that even the most expensive therapeutic foster care program compares favorably with treatment in group settings, including group homes, residential treatment centers, or hospitals (Snodgrass & Bryant, 1989; Webb, 1988; Welkowitz, 1987). Bryant (1980a; 1981) cited evidence of the cost-effectiveness of early therapeutic foster care programs. The Alberta Parent Counselors Program provided treatment in therapeutic foster homes to 100 emotionally disturbed children who would have been institutionalized at half the cost of institutional care; the Massachusetts Treatment Alternative Project served children scheduled to enter residential treatment centers at two-thirds the cost; and People Places provided treatment to severely disturbed youngsters at half the cost of institutional treatment. An evaluation of the Parent Therapist Program demonstrated that the improvements made by youngsters in therapeutic foster care were comparable to the improvements made in traditional residential treatment centers, and the per diem cost in therapeutic foster care was approximately one-half that of the centers.

More recently, Beggs (1987) compared the costs of therapeutic foster care with estimated costs of other forms of residential treatment in California, as follows:

- Therapeutic foster care - $1030 - $2106 per month
- Group homes - $2100 per month
- Sub-acute facilities - $6000 per month
- Acute hospitals - $8000 per month

Snodgrass and Bryant (1989) reported that 92 percent of the programs responding to their survey reported their costs to be lower than group home or institutional programs. In addressing the cost-effectiveness of therapeutic foster care, Jones (1989) concluded that "therapeutic foster care may represent the least expensive residential treatment for problem children, and therapeutic foster care appears capable of serving children, for less cost and with successful results, who otherwise would be treated in group care facilities."

The cost data on therapeutic foster care excludes those costs incurred during the initial program development phase. Programs typically require federal, state, or foundation grants to cover the costs of program implementation. While special development funds may be required, the start-up costs for therapeutic foster care are far less than start-up costs for other types of residential treatment programs primarily because therapeutic foster care programs do not require the purchase or renovation of an actual building. Substantial savings also is realized for ongoing program operations since no agency-operated physical facility is required beyond office space for program staff (Hawkins & Luster, 1982).

Initial costs generally cover recruiting and training program staff and recruiting, selecting, and training treatment parents. Additionally, start-up funds may be needed to support early program operations as the census of children in placements is built up to the point that reimbursements cover costs. Meadowcroft and Luster (1989) estimate that from the placement of the first child to the "break-even point" takes about one year for programs funded on a fee-for-service basis. This is not a concern for programs on a fixed budget, since funding is not dependent upon the census of children.

Therapeutic foster care programs typically are funded by public agencies, primarily child welfare agencies, mental health agencies, or, increasingly, both of these agencies through collaborative funding arrangements. Depending upon the procedures used to fund service delivery in a particular state, funding may come directly from the state agency or may be handled through the local agency.

COSTS OF THERAPEUTIC FOSTER CARE SERVICES

Program	Year	Per Diem Cost	Reference
Children's Garden San Rafael, CA		$34/day	Beggs, 1987
East Arkansas Regional Mental Health Center Helena, AR		$55/day	Program Literature
Future Families Aptos, CA		$51/day	Beggs, 1987
Futures Unlimited St. Johnsbury, VT	1987	$42/day	Welkowitz, 1987
Individual Residential Treatment Lee Mental Health Center Fort Myers, FL	1986	$64/day	Site Visit
Love, Inc. Vergennes, VT	1987	$36/day	Welkowitz, 1987
Maryland Specialized Foster Care Demonstration Programs		$52-$62/day	Maryland Dept. of Human Resources, 1987
Northeastern Family Institute Professional Parenting Program Burlington, VT	1987	$55/day	Welkowitz, 1987
Parent Therapist Program Akron, OH	1986	$64/day	Update, 1986
People Places Staunton, VA	1988	$36/day	Meadowcroft, Luster, & Fabry, 1989
Professional Parenting Morganton, NC	1988	$36/day	Meadowcroft, Luster, & Fabry, 1989
PRYDE Pittsburgh, PA Lebanon, NH	1988	$55/day	Meadowcroft, Luster, & Fabry, 1989
St. Vincent's School for Boys Marin County, CA		$42/day	Beggs, 1987

COSTS OF THERAPEUTIC FOSTER CARE SERVICES, CONTINUED

San Francisco Therapeutic Homes Program San Francisco, CA		$70/day	Beggs, 1987
Upper Valley Youth Services Therapeutic Foster Care Program Lebanon, NH	1987	$55/day	Welkowitz, 1987
Washington County Professional Foster Care Program Barre, VT	1987	$49/day	Welkowitz, 1987

Title IV-E of the Social Security Act provides federal reimbursement to states for foster care maintenance payments for eligible children (i.e., children whose families received or were eligible for Aid to Families with Dependent Children [AFDC] prior to court proceedings leading to removal). It can also subsidize foster care maintenance payments for up to six months for eligible children removed from their homes on the basis of voluntary placement agreements and for extended periods if a court rules that the placement is in the best interest of the child. Through this mechanism, a portion of the cost of therapeutic foster care (the maintenance portion) is financed by federal funds for some percentage of the population served. Other federal funds (e.g., Title XX Social Services Block Grant funds), state funds, and, in some cases, county funds are all used to finance therapeutic foster care services to varying degrees.

Some programs attempt to take advantage of opportunities to receive third-party reimbursement for their services. These programs bill Medicaid and private insurers for the portions of therapeutic foster care that might be covered. For example, programs may be able to receive reimbursement for individual or family therapy, psychiatric services, case management, and other component parts of the therapeutic foster care approach. Some programs report that any third-party reimbursements collected that duplicate public agency funding must be rebated to the public funding agency.

In addition, some programs report that fees on a sliding scale basis are assessed to the child's family. In the Lee Mental Health Center program, for example, a contract with natural families includes an agreement to pay a specified amount for treatment on a monthly basis. The feasibility of fee collections from family, however, is questionable, and fees generally comprise an insignificant percentage of program revenues. Some programs receive additional support from foundations or endowments.

The majority of therapeutic foster care programs are funded through one of two mechanisms. The purchase-of-service contract appears to be the most common approach, with the public agency providing per diem reimbursement at a negotiated rate for each unit (i.e., day) of service to a child. A problem reported by programs is that some states and counties are reluctant to pay full program costs and attempt to negotiate lower per diem rates. A second approach involves a fixed amount service grant to a program, providing a predetermined level of funding to the program for a specified time period. Performance standards specifying such things as the number of children to be served and number of days of service to be provided may be attached to the grant mechanism.

EVALUATION

The extent and sophistication of program evaluation efforts vary considerably across programs. Elaborate evaluation methodologies are time-consuming and expensive to implement and often are beyond the means of therapeutic foster care programs, many of which are small and at early stages of development (Jones, 1989). Few programs have received funding specifically to support evaluation research. Despite the difficulty in allocating scarce resources to evaluation, most programs do collect some data for internal quality control purposes and to meet the requirements of external funding and regulatory agencies. The evaluation indices most commonly used by programs include placements following discharge, improvements in functioning, and satisfaction with services.

To date, much of the evaluation of the effectiveness of therapeutic foster care has relied upon discharge data. There appears to be agreement among programs that a "successful discharge" is one in which the youngster leaves the program and is able to go into a less restrictive setting. A less restrictive setting may be the youngster's own home, an adoptive home, a foster home, or independent living. It is assumed that, in order to be able to move into a less restrictive setting, the youngster has demonstrated progress within the program and has successfully completed most treatment goals. A discharge is considered unsuccessful if the youngster leaves the program and enters a more restrictive setting such as a group home, residential treatment center, psychiatric hospital, or correctional facility. Thus, program effectiveness may be presented in terms of the percentage of successful discharges, i.e, the percentage of youth who were able to enter less restrictive settings upon discharge. The extent to which children enter less restrictive settings is considered a fundamental measure of a program's success (Jones, 1989; Snodgrass & Bryant, 1989).

The exhibit on the following pages summarizes discharge data published by a number of therapeutic foster care programs. The rates of successful discharge reported by programs range from a low of 62 percent to a high of 89 percent for a 1977 sample of discharges from People Places. While there may be some lack of consistency in each program's definition of "less restrictive" and "more restrictive" settings, the majority of children across programs appear to be discharged from therapeutic foster care to less restrictive settings. In the survey conducted by Snodgrass and Bryant (1989), across all respondent programs, an average of 77 percent of the children are discharged to less restrictive settings (44 percent to their own or relatives' homes, 16 percent to independent living situations, 6 percent to adoptive homes, and 16 percent to regular foster care). No agency reported placing fewer than 50 percent of youngsters in less restrictive environments at discharge. Based upon his review of program data, Jones (1989) suggested that programs might anticipate an approximate rate of successful discharges of 75 percent.

These data suggest that therapeutic foster care programs do have the potential to divert youngsters from more restrictive residential placements. However, the data reflect only the nature of the placement at the time of discharge from therapeutic foster care and do not address longer term placement outcomes. If one of the goals of therapeutic foster care is to prevent more restrictive residential placements, then it is essential to examine not only the short-term results but also to collect follow-up data regarding placement status. Unfortunately, most information on post-discharge placements relates to the immediate transition from therapeutic foster case, and few programs routinely collect follow-up information (Snodgrass & Bryant, 1989; Welkowitz, 1988).

One exception is the PRYDE Program which collects follow-up information on discharged children on an annual basis. The program attempts to determine where the youths are living, whether they are attending school or are employed, and whether there have been any incidents of antisocial behavior or police contact. PRYDE's findings suggest sustained positive outcomes over time, with more than 70 percent of the discharged children still living in less restrictive settings at one and two years post-discharge and over 70 percent of the youngsters either attending school or being employed. Problems were reported for small percentages of the discharged youngsters: 9 and 12 percent had alcohol and drug problems; 9 percent had engaged in aggressive acts; and 23 percent had police contacts (Jones, 1989). PRYDE's follow-up data lend support for claims regarding the long-term effectiveness of therapeutic foster care services. However, it is apparent that the lack of follow-up information from most programs represents a major shortcoming in the evaluation of therapeutic foster care, and systematic follow-up studies are needed to document the long-term outcomes of these services (Beggs, 1987).

Several evaluations have looked beyond post-discharge placements to assess improvements in the child's functioning, and the results also are suggestive of positive outcomes. In some programs, assessment of improvement in functioning involves tracking changes in the behaviors or problems which were documented at the time of admission. For example, People Places documents "target behaviors" at the time of admission, and at the time of discharge staff rate

DISCHARGE DATA FOR THERAPEUTIC FOSTER HOME PROGRAMS

Program	Discharge Data	Reference
Family and Children's Society Baltimore, MD	12% discharged to institutional settings over 3-year period	Waskowitz, 1954
Florida Therapeutic Foster Care Programs	73.4 returned home or discharged to less restrictive setting	Friedman, 1983
Future Families Aptos, CA	78% discharged to less restrictive setting 18% placed in residential treatment	Beggs, 1987
Kaleidoscope Therapeutic Family Homes Program Chicago, IL	62% discharged to less restrictive setting	Site Visit
Missouri Division of Family Services Foster Family Treatment Program	74% discharged to less restrictive environment	Bryant, Simmons, & McKee, 1987
Northeast Mental Health Center Memphis, TN	64% discharged to less restrictive environment	Program Materials
People Places Staunton, VA	89% discharged to less restrictive settings 11% placed in institutions (1977 discharges)	Witters & Snodgrass, 1982
	86% discharged to less restrictive settings (1981 discharges)	Jones, 1989
Professional Parenting Morganton, NC	79% discharged to less restrictive settings	Jones, 1989

DISCHARGE DATA, CONTINUED

PRYDE Pittsburgh, PA	72% discharged to less restrictive settings	Meadowcroft, 1988 Jones, 1989
	73% still in less restrictive settings 1 - 2 years post-discharge	Hawkins, Meadowcroft, Trout, & Luster, 1985
	82% discharged to less restrictive settings (1984 discharges)	
San Franciso Therapeutic Family Homes Program San Francisco, CA	80% discharged to less restrictive settings 17% placed in residential treatment centers	Beggs, 1987
St. Vincent's School for Boys San Rafael, CA	13% discharged to residential treatment or group homes	Beggs, 1987
Wisconsin Treatment Family Care Program Fond du Lac and Green Bay, WI	64% discharged to birth parents, adoptive parents, or independent living 29% discharged to other substitute care in community 7% placed in institutions	Bauer & Heinke, 1976

the status of these same target behaviors. For two samples of discharged children (1977 and 1981 samples), an average of more than 75 percent of the target behaviors were rated as significantly improved. Target behaviors were rated again at two and seven months post-discharge, and it was found that an average of 80 percent of the target behaviors were considered to be "no problem" or "some problem but improving" (Jones, 1989; Snodgrass & Campbell, 1981; Witters & Snodgrass, 1982). In an evaluation of Florida's programs, Friedman (1983) found that 60 percent of the youngsters discharged from therapeutic foster care made significant progress on their behavioral objectives and another 25 percent made slight progress. Similarly, the Parent Counselors Program in Alberta, Canada, found that most youngsters improved significantly in self-esteem and made progress with respect to more than half of the problem behaviors which were identified in their treatment plans (Bryant, 1980a; 1981).

The Maryland Department of Human Resources (1987) attempted to be more rigorous in evaluating improvement in functioning associated with therapeutic foster care by administering the Achenbach Child Behavior Checklist, the Functional Status Index, and other instruments at the time of placement and six months post-placement. The results of this evaluation are particularly encouraging since almost all categories of behavior problems decreased for youngsters in therapeutic foster care, while increased behavior problems were found for a control group (comprised of children referred to therapeutic foster care but not placed). These evaluations indicate that therapeutic foster care does result in improved behavior and functioning. Cox and Cox (1989) urge that behavioral and functional improvements be measured routinely along with placement outcomes in order to adequately assess the effectiveness of therapeutic foster care services.

There have been some limited attempts to identify factors which may be associated with positive outcomes, based upon improvement in functioning, in therapeutic foster care programs. In the Florida programs, the youngest children made the largest gains, and the highest percentage of negative outcomes was in the 15 to 17-year-old age group (Friedman, 1983). People Places also found that younger children were more successful at achieving goals, and the Alberta Parent Counselors Program found that children with no history of prior placements made more significant positive changes than those with multiple prior placements (Welkowitz, 1987). While these findings imply that younger children and those without extensive placement histories may be most successful in therapeutic foster care, firm conclusions cannot be drawn on the basis of such limited data.

In addition to discharge placements and improvements in functioning, programs often measure satisfaction with services as part of their evaluation efforts. For therapeutic foster care, satisfaction may be assessed from a variety of perspectives, including those of youngsters, natural parents, and treatment parents. The Lee Mental Health Center, for example, periodically conducts a client satisfaction survey that includes children over age 10 and all natural parents. PRYDE includes youth ratings of satisfaction with treatment parents as an integral part of the program's evaluation of treatment parents' performance. In order to focus on the perspective of treatment parents, Professional Parenting administered questionnaires designed to assess their satisfaction with the extent and quality of the training and support services provided by the program. The majority of treatment parents reported high levels of satisfaction with training, with consultation provided by staff, and, surprisingly, with level of remuneration (Jones, 1989). Professional Parenting also attempted to evaluate the effects of treatment parenting on the functioning of treatment families. Pre- and post-placement interviews with a sample of treatment families were conducted to assess satisfaction with social, recreational, occupational, and marital aspects of their lives. Comparable levels of satisfaction were found in most domains at both pre- and post-placement measurements, leading to the conclusion that the placements do not have debilitating effects on the life routines and satisfaction of treatment families (Jones, 1989).

A major shortcoming in the evaluation of therapeutic foster care has been the dearth of studies using comparison or control groups. Research comparing therapeutic foster care to other treatment conditions is rare, with only one attempt at such a comparison reported in the literature to date (Rubenstein, Armentrout, Levin, & Herald, 1978). The study focused on the Parent Therapist Program and included a population of 6 to 12-year-olds who were assessed as being in need of residential treatment. A multidisciplinary team was used to assign children either to the Parent Therapist Program or to one of two participating residential treatment centers in the area. While assignments were not completely random since space availability factors had to be considered in placement decisions, the groups placed in therapeutic foster care and the other settings were comparable. The study revealed that both therapeutic foster care and residential treatment approaches resulted in significant improvement in the severity of behavioral problems; there were no significant differences in treatment outcomes among groups. However, the Parent Therapist Program was able to achieve comparable outcomes at approximately one-half the cost of the residential treatment centers. Beyond cost advantages, the researchers emphasized that there are powerful intangible benefits of placement in well-functioning families that cannot be measured. Given comparable treatment outcomes, the benefits of a home environment weigh heavily in favor of the therapeutic foster care approach. An "informal comparison" of People Places with a residential treatment center in the area also suggests that therapeutic foster care can provide effective services in less restrictive and less costly family environments than is possible in institutions (Bryant, 1983).

A study which is currently underway may begin to fill the gap in evaluation of therapeutic foster care caused by the lack of reliable comparison data. The study is described as a comparative evaluation of several types of programs for severely emotionally disturbed children and youth (Almeida, Hawkins, Meadowcroft, & Fabry, 1988; Almeida, Meadowcroft, Hawkins, & Luster, 1989). The study sample is comprised of approximately 460 children who were referred to the PRYDE Program and were considered acceptable candidates for admission. Due to the limited number of treatment homes, only 26 percent of these youngsters were placed in PRYDE homes; the other youngsters were placed in residential treatment centers (23 percent), special foster care (18 percent), group homes (9 percent), intensive treatment units (21 percent), or returned home (12 percent). The groups in these various placements were found to be generally comparable, allowing a comparison of outcomes across a range of treatment environments.

The primary outcome variables considered in this study are the restrictiveness of the setting to which the youngsters were discharged from the initial "target" setting and the duration and frequency of placements after discharge. Secondary outcome data include such factors as the costs of the target placement and of post-discharge placements to permit a cost-effectiveness assessment. Initial results have indicated that, on average, PRYDE discharged youngsters to less restrictive settings than other target programs. PRYDE discharged the most youngsters to family or independent living situations (61 percent), and had the largest number of youngsters remaining in such situations after a period of one year post-discharge. Further, youth placed in PRYDE spent the least amount of time in out-of-home placements following discharge than youth from any other target program during the time frame of the study. The researchers speculated that a treatment setting within the context of a family and community may help youngsters learn to function, and thereby remain, in these environments. It is interesting to note that of the youngsters who were referred to PRYDE but remained at home rather than entering PRYDE or another of the target programs, more than 50 percent left their homes within an average of 6.8 months and spent the longest time in subsequent out-of-home placement than any other group.

While only preliminary and partial analyses of the study data have been completed to date, the researchers have tentatively suggested several important findings:

- Many youngsters who apparently could be served in a minimally restrictive program like PRYDE are instead served in much more restrictive settings.
- PRYDE appears to discharge youngsters to significantly less restrictive environments than do residential treatment centers or intensive units and discharges the most children to their own homes, adoptive homes, or independent living.
- PRYDE costs less, on a daily basis, than any of the other treatment programs included in the study with the exception of the specialized foster care program.

The researchers concluded that "at least the PRYDE version of [therapeutic foster care] is a viable and effective alternative to more restrictive residential settings for at least some children. Thus, if more PRYDE families were available, most, if not all, of the children referred to PRYDE could have been served in less restrictive family environments and apparently with at least as good success" (Almeida, Hawkins, Meadowcroft, & Luster, 1989).

A study conducted in Oregon was designed to test the effectiveness of therapeutic foster care for youngsters who were institutionalized at the Oregon State Hospital. The children included in the study ranged in age from 9 to 18 and were all hospitalized for severe emotional disturbance or psychiatric problems, meeting the criteria of being dangerous to themselves or others. Children referred for post-hospital planning were randomly assigned to a therapeutic foster care (experimental) group or to "treatment as usual" in their communities; there were no significant differences between groups with regard to clinical and family characteristics or a number of risk variables. The study revealed that all 10 of the children referred to therapeutic foster care actually were placed in treatment family settings, whereas only 4 out of 10 controls were placed in family settings and 3 control subjects remained in the hospital. Over a one-year period, the average amount of time spent in community placements was higher in the therapeutic foster care group than in the control group, leading investigators to conclude that the use of therapeutic foster care has tremendous potential as a treatment model even for the most distressed groups of children (Chamberlain, 1988).

Friedman (1989) underscored the importance of carrying out more and better evaluation efforts relative to therapeutic foster care, noting the dearth of studies which directly compare different residential treatment models. Additionally, he charged that inadequate descriptions of the youngsters and families served by programs is the "weak link" in the evaluation of therapeutic foster care. The lack of objective data on the population served makes it impossible to determine the comparability of children in different programs and, thus, to evaluate program effectiveness. Friedman called for a voluntary effort among therapeutic foster care programs to collect some comparable data on the population served.

An important caveat raised by Friedman (1989) relates to the context for evaluating therapeutic foster care. Most research and evaluation of therapeutic foster care programs have focused on demonstrating that they are viable alternatives to more restrictive and costly residential treatment environments. However, Friedman asserted that studies also should compare therapeutic foster care with even less restrictive, nonresidential services. Given the current philosophical and legal emphases on providing treatment within the least restrictive environment, there is an increasing emphasis on keeping children within their own homes if at all possible and on providing intensive nonresidential services and supports in order to support family functioning. According to Friedman, it is important for therapeutic foster care services to be evaluated as part of an overall system of care with effective and intensive nonresidential services which minimize the use of all types of out-of-home placements.

Despite the shortcomings of the evaluation efforts, Friedman concluded that "the evidence for the value of therapeutic foster care is clearly sufficient to justify the continuation and even the growth of such programs."

MAJOR ADVANTAGES AND CHALLENGES

Advantages

The advantages of therapeutic foster care have been reviewed extensively in the literature (Bryant, 1983; Bryant & Snodgrass, 1989; Friedman & Zeigler, 1979; Hawkins & Luster, 1982; Hawkins, Meadowcroft, Trout, & Luster, 1985; Meadowcroft, 1988; Meadowcroft & Luster, 1989). The responses of staff, program administrators, staff from other community agencies, treatment parents, and families received during site visits also lend an invaluable perspective in identifying the strengths of the therapeutic foster care approach. While by no means exhaustive, some of the major advantages of therapeutic foster care are summarized below:

o Therapeutic foster care provides a minimally restrictive, natural environment for treatment.

Current trends across child-serving systems call for treatment in the least restrictive, most normalized environment. Therapeutic foster care is considered the least restrictive of the residential treatment options for emotionally disturbed children. The treatment home environment poses the fewest limitations on the child's activities, social contacts, and physical environment while providing a therapeutic environment along with planned treatment interventions and high levels of supervision and support.

In addition to offering a minimally restrictive setting, therapeutic foster care provides the most normalized type of residential treatment environment. It generally is agreed that the first and greatest investment should be made in the care and treatment of youngsters within their own homes and in preserving family integrity. However, when separation from the natural family is unavoidable, therapeutic foster care provides the closest approximation of a normal family environment that can be achieved in an out-of-home setting. Children live in families and can attend community schools, be involved in community activities, and utilize community resources. Thus, this family-based treatment model is less restrictive and more normalized than most other residential treatment options.

o The family environment of therapeutic foster care enhances generalization of treatment gains as well as opportunities for positive modeling effects.

Most children in residential treatment eventually will return to a family structure of some type, whether it be their own or a substitute family. The family treatment setting provided by therapeutic foster care most closely approximates the setting to which the child must adjust permanently. The similarity of environments maximizes the transfer or generalization of therapeutic gains to subsequent situations; learnings do not have to be generalized to totally new types of environments. Further, the treatment home environment can be viewed as a training ground, providing myriad naturally occurring opportunities for modeling and learning relationship, community living, and parenting skills. Much "incidental" learning occurs simply by being a part of a healthy, well-functioning family group.

In addition to opportunities for positive modeling effects from both treatment parents and siblings, the therapeutic foster care approach helps to reduce the effects of negative peer influence often found in group treatment settings. Group treatment settings typically are challenged by the problems of peer modeling and reinforcement of unacceptable behaviors, with the accompanying risk that children may acquire further maladaptive behavior patterns while in the treatment setting. This negative peer modeling effect is minimized by working with children individually in the context of treatment homes.

o Therapeutic foster care is highly flexible and, therefore, can be used to serve a wide range of youngsters.

The client population that potentially can be served within therapeutic foster care is broad and diverse. Because children are not grouped together within a single facility, therapeutic foster care programs can easily serve children of different ages, sexes, and with different types of problems without concern for the "mix" of children in a treatment setting. While many therapeutic foster care programs focus on serving children with serious emotional and behavioral problems, the approach is used to serve diverse populations including teenage mothers and their babies, physically and multiply handicapped youngsters, and children with serious medical problems such as AIDS. The therapeutic foster care model has the inherent capability and flexibility to adapt to these and other special needs by selecting treatment homes and designing treatment programs based upon the individual needs and characteristics of each youngster. Meadowcroft & Luster (1989) emphasized that the range of children and adolescents potentially served with therapeutic foster care is limited only by the lack of appropriate treatment families, uncreative treatment technologies, or inadequate professional supervision.

o Therapeutic foster care provides highly individualized treatment for each youngster.

With some exceptions, only one child typically is placed with each treatment family. This provides a unique opportunity to design the entire treatment intervention specifically to meet the needs of each child. Individualization begins during the matching process when a treatment family is carefully selected to provide the best combination of characteristics and skills to assist the particular child. Treatment interventions are targeted to the child's specific problems, and the close, daily interactions with the treatment parents allow for continuous observations, assessment of progress, and adjustment of treatment techniques. The support and ancillary services provided by the program also can be reconfigured to meet individual needs; additional staff and resources can be "plugged in" in order to maintain the placement and treatment program for the child. Thus, the services provided by therapeutic foster care programs are highly individualized, and each participating youngster may have a significantly different experience.

o Therapeutic foster care provides youngsters with a sense of "family connectedness."

The relationship that develops between children and treatment parents has been described as a primary bond (Knickerbocker & Langford, 1978). Although placement in the treatment home may be temporary, the bond often is long-term, and youngsters are likely to remain in touch with treatment parents far beyond their discharge from the therapeutic foster care program. As a result, the connection to a highly functioning family continues over time. Communication between the youngster and treatment parents may occur on special occasions such as holidays or birthdays, and treatment parents often are accessible to youngsters in times of stress or crisis. In many cases, the treatment family becomes part of the youngster's extended family (Meadowcroft & Luster, 1989). Meadowcroft (1988) stated that even when a child is able to successfully return home, he or she always has the treatment family to turn to.

- There is less negative community reaction to therapeutic foster care than to other types of residential programs.

In implementing therapeutic foster care services, programs rarely face the zoning battles and community resistance which so often accompanies the establishment of group homes and other residential facilities. Therapeutic foster care, which does not require an identifiable facility, is less visible within a community and avoids these negative community responses.

- Start-up costs for therapeutic foster care are minimal as compared with other types of residential treatment services.

Since no special physical facility is required, therapeutic foster care programs avoid the major capital outlay involved in obtaining land, buildings, furnishings, and equipment. As a result, start-up expenses are far less than those associated with group homes, residential treatment centers and the like.

- Therapeutic foster care is significantly less expensive than other types of residential services.

The cost of therapeutic foster care, ranging from approximately $35 to $150 per day, compares favorably with the cost of other residential services. Evidence is mounting that therapeutic foster care programs are able to effectively serve children who otherwise would have been placed in more expensive residential treatment settings. If therapeutic foster care services were more widely available, substantial cost savings could be realized in addition to the other, less tangible benefits of the therapeutic foster care approach.

In addition to offering a more cost-effective service model, therapeutic foster care also allows a larger percentage of the resources to be spent on actual treatment. The expenses associated with such things as maintaining buildings, grounds, equipment, and food service that are required in most other types of residential programs are avoided. Further, programs can be expanded and contracted based upon demand. Unlike other residential treatment settings, empty beds do not create financial difficulties.

Challenges

A number of problems related to the development and delivery of therapeutic foster care services also have been identified. These are presented as "challenges" that should be considered and addressed in implementing and operating therapeutic foster care programs:

- Recruiting qualified treatment parents.

The success of a therapeutic foster home program is largely dependent upon the availability and quality of treatment homes. Recruitment of highly qualified treatment parents was cited most frequently as the most critical challenge facing therapeutic foster care programs. Recruiting the initial pool of treatment parents may be particularly difficult for new programs, creating a significant lag time before the actual placement of children. In new programs with a limited pool of treatment parents, referrals may have to be declined rather than placing children in homes that are not well-suited to their needs. On an ongoing basis, programs report difficulty in finding treatment parents who are both willing and capable of working with severely disturbed youngsters. Programs have found that a continuous commitment to recruiting and training treatment parents is needed to ensure an adequate supply of treatment homes. In some areas, special recruitment efforts are needed to attract qualified minority treatment parents.

o Developing and maintaining a reliable referral system.

Creating and maintaining a referral system is a challenge faced by all therapeutic foster care programs. Difficulties in this regard stem largely from lack of knowledge about therapeutic foster care on the part of potential referring agencies. Referring agencies and personnel may have difficulties distinguishing between regular foster care and therapeutic foster care and may not feel that "foster care" is an appropriate environment for seriously emotionally disturbed children. Agencies may favor more traditional placements for troubled youngsters, based on the fallacious assumption that secure treatment settings are required for most children. It is apparent that in order for a therapeutic foster care program to succeed, considerable effort must be expended to educate referring agencies about the type of treatment provided through therapeutic foster care programs and the population that potentially can be served. Such outreach and education efforts have been successful in overcoming skepticism and resistance on the part of the child serving agencies that can act as referral resources.

o Obtaining appropriate special education placements and services.

Of all the community agencies with which they work, therapeutic foster care programs characterize relationships with school systems as the most challenging. Most children in therapeutic foster care are in need of special education services of some type, and a child's failure to adjust at school can create insurmountable obstacles to the success of the therapeutic foster care intervention. Programs report that they spend a great deal of time and effort coordinating services with the schools. However, many programs work with multiple school districts and meet with varying responses, specifically a reluctance to accept foster children with special needs and to provide special education services. Because of the critical impact of the child's educational placement, and because of these potential problems, most programs devote a great deal of attention to their relationships with school systems.

o Maintaining a collaborative relationship with the child welfare agency.

The therapeutic foster care model is highly dependent upon close coordination between the program and the child welfare agency. Many children in treatment homes are in the custody of the child welfare agency; programs also may be funded or regulated by this agency. Maintaining collaborative working relationships with the child welfare agency can be problematic due to turf issues, disputes over appropriate placements and treatment for individual youngsters, delays or disagreements over the licensing of treatment homes, overlap and confusion surrounding the "case management" role, and the like. High turnover rates among child welfare staff complicate the efforts of some programs to cultivate and maintain effective linkages. Programs must develop strategies to coordinate services with the child welfare agency as well as with the range of agencies and systems that share responsibility for troubled youngsters and their families.

o Engaging natural families in services.

Working with natural families is reported to be one of the most challenging aspects of therapeutic foster care and, thus, is one of the most inconsistent activities across programs. While early programs were skeptical about the value of working with natural families, programs increasingly are recognizing the importance of actively and effectively involving natural parents in the service delivery process. Nevertheless, programs encounter a range of barriers and difficulties in these efforts, including geographic distances, lack of transportation, and lack of reimbursement for working with natural families. Further, some natural families may have long-standing, multiple problems or may be unresponsive to program efforts. Despite these difficulties, the natural family has a crucial influence on the child's ultimate adjustment, and therapeutic foster care programs must strengthen the intervention approaches used with natural families.

o Handling allegations against treatment parents.

An inevitable occurrence for therapeutic foster care programs is an occasional allegation of abuse against a treatment parent. Most programs have experienced at least several such allegations made by youngsters, but reported that none has resulted in a finding of actual abuse. In most cases involving abuse allegations, the youngster is removed from the treatment home temporarily while the situation is investigated. Through preservice and inservice training, treatment parents are prepared for the possibility of abuse allegations and are apprised of the process that will be followed for reporting, investigating, and resolving each incident. Programs emphasize the importance of maintaining the stance of "innocent until proven guilty" with respect to their treatment parents and of continuing to support them through these types of trying circumstances.

o Handling the disturbing behavior of youngsters.

Just as in other types of residential programs, therapeutic foster care programs invariably are faced with incidents of acting out, violent, or destructive behavior on the part of youngsters. Most programs report that there have been no life threatening injuries to others committed by youngsters in care, but acknowledge occasional incidents involving threats, striking a family member, sexual abuse of another child in the home, theft, or property destruction in the treatment home or neighborhood. Each program has specific procedures for handling such incidents, including the involvement of law enforcement agencies when appropriate. In the case of property destruction, some programs maintain a contingency fund to reimburse the treatment family or neighbors for any damage, and the child may be required to make restitution by earning the money needed to pay for damages.

Given the severity of the problems of many of the children in care, incidents of disturbing behavior are unavoidable. Nonetheless, these situations are difficult and uncomfortable for treatment parents, staff, and youngsters alike. Programs should be vigilant in weighing the potential risk to the community posed by placing a youngster in an open treatment environment such as a treatment home. Bryant (1983) stated that treatment homes are by their very nature less secure and protective of the community than institutions, and it is incumbent upon programs to determine which youngsters can be served most safely and do not represent a clear danger to others or to the community. Each program will make this determination based upon its resources, capabilities, and limitations. Some programs successfully serve children considered dangerous to themselves or others by using highly skilled treatment parents and adding resources, such as in-home staff assistance, additional staff consultation, and home modifications for security.

o Providing follow-up services.

The purposes of follow-up services are to ensure that a successful adjustment to the post-discharge placement is made and that needed ongoing treatment and services are provided without interruption. In most therapeutic foster care programs, the follow-up component is either limited or totally nonexistent, and, once a child leaves the treatment home, the intensive support decreases dramatically. The difficulty in providing follow-up services generally is attributed to a lack of funding for this aspect of service delivery. As noted, the lack of more extensive follow-up services may have significant implications for the long-term effects of therapeutic foster care due to the importance of the post-discharge environment in determining successful long-term adjustment. Accordingly, programs are increasingly recognizing the importance of the follow-up component and are seeking resources to support improved aftercare.

- Obtaining independent living services.

Many therapeutic foster care programs serve older adolescents, with some programs specializing in serving this population. In many cases, these youngsters remain in treatment homes until they reach maturity and move from treatment homes to independent living situations. Whether or not they are emancipated immediately upon discharge, older adolescents are in need of services designed to help them meet the demands of independent living, including daily living skills and vocational skills. These types of services are in short supply, and programs report that it is very difficult to obtain independent living services appropriate to the needs of emotionally disturbed adolescents. There is a clear need for curricula and training materials that can be used by treatment parents and staff to help youngsters develop community living and vocational skills (Snodgrass & Bryant, 1989).

- Preventing burnout among treatment parents and staff.

The jobs of both treatment parents and staff in therapeutic foster care programs are demanding and stressful. The expectations of treatment parents are high; they must maintain a commitment to ongoing training and to their professional role and cope with 24-hour exposure to children with severe problems. Staff play a wide variety of roles in their work with treatment parents, children, natural parents, and community agencies and must cope with such things as erratic schedules, 24-hour on-call responsibilities, and enormous travel requirements. As a result, burnout is a persistent danger among treatment parents and staff. Programs have devised many creative ways of minimizing burnout, including maintaining small caseloads and providing extensive training and consultation, strong agency and peer support, good benefits, and a host of other strategies for acknowledging and supporting staff and treatment parents.

- Obtaining liability insurance coverage for treatment parents.

Some programs reported that they have had difficulty securing liability insurance coverage for treatment parents. Many treatment parents would feel more comfortable with additional insurance to protect them against property damage and injury in their homes and neighborhoods as well as from lawsuits. Such coverage generally has been unavailable or very expensive. Some states are beginning to recognize this need and provide liability coverage to protect foster parents who are providing a valuable public service. In Iowa, for example, the State provides liability coverage for all foster parents. Legislation recently was passed in Maine which provides broad liability insurance coverage to foster parents in the State. The program defends foster parents if they are sued for negligence, physical abuse, sexual abuse, or alienation of affection and offers enhanced protection for damage to property caused by foster children (Focus FFTA, 1989).

- Returning children to troubled natural families.

A problem cited by treatment parents and staff involves the difficulty in returning children to homes that continue to be troubled. Some programs report that the pressure to reunite families may result, in some cases, in returning children to families who have made little progress and are not likely to support and continue the gains made by the child in the treatment home setting. This circumstance is described as "devastating" for both treatment parents and staff. Suggestions for responding to this problem include vastly increasing the extent and quality of services provided to natural families along with greater adherence to service and performance agreements for natural parents.

PROGRAM DEVELOPMENT

Starting a new therapeutic foster care program can present substantial challenges. Many programs report that an ample period of time is required to accomplish all the necessary tasks involved in implementing a new program, ranging from obtaining office space and licensure to recruiting and training treatment parents. Meadowcroft and Luster (1989) estimated that a start-up period of 5 to 24 months will be required for program development depending upon the obstacles encountered during the implementation process. The duration of the start-up phase can be decreased somewhat by hiring experienced staff and by adapting existing training packages. The PRYDE Program has had considerable success in "seeding" programs in new areas with a core group of experienced PRYDE staff. In reporting on the development of therapeutic foster care pilots in Missouri, it was recommended that program developers estimate the start-up time that they anticipate will be needed for tasks including recruiting treatment parents and preparing staff and then double it (Bryant, Simmons, & McKee, 1987)!

While therapeutic foster care programs do not require the timely and expensive process of purchasing, leasing, or renovating a facility, a number of critical tasks must be accomplished during the start-up period. Meadowcroft and Luster (1989) indicated that program implementation involves creating the local climate for the program, designing and developing materials to define what the program will be, determining and describing the population of children to be served, hiring sufficient staff to allow for program growth, recruiting and training the first group of treatment parents, and securing funding to support the planning phase and operations until the program becomes fiscally viable.

One of the most important start-up tasks described by Meadowcroft and Luster is "creating the climate" for the program within the community. The importance of cultivating an atmosphere of acceptance for therapeutic foster care stems from the high probability of encountering skepticism and resistance from some professionals and policymakers within the community. Such skepticism results primarily from lack of familiarity with the concept and operation of therapeutic foster care; some may have difficulty believing that highly intensive treatment can be provided in family environments as effectively as in hospitals or residential treatment centers. Since intensive treatment often is equated with a physical building or "treatment facility," the lack of a physical presence and the use of natural environments may be difficult for people to accept or trust. Further, some policy makers may have difficulty differentiating therapeutic foster care from regular foster care, and may view the program merely as expensive foster care.

Meadowcroft and Luster (1989) suggest a variety of strategies for confronting possible resistance and creating an appropriate climate for program development. These include meeting with key professionals and politicians to explain therapeutic foster care; disseminating information about the children served in existing programs and data on program outcomes; disseminating financial information from existing programs to establish the cost-effectiveness of therapeutic foster care; and obtaining letters of endorsement or personal testimonials from professional staff, treatment parents, youngsters, juvenile court judges, or other public officials who have been involved with therapeutic foster care services. It can be particularly helpful to document that therapeutic foster care can be effective in preventing more restrictive placements and that the youth served differ significantly from those in regular foster care (Bryant, Simmons, & McKee, 1987).

One of the advantages of therapeutic foster care is that programs can be started on a small scale and increase in size and scope over time. Barnes (1980) warned that program development should be seen as a gradual process and that programs should avoid the tendency to overextend themselves during early implementation phases. Accordingly, programs might limit the number of children served during the first year and undertake a gradual process of expansion over the next several years. It should be noted, however, that a program size of at least 20 children, one administrator, three staff, plus consultants and support personnel may be needed to ensure program viability (Meadowcroft & Luster, 1989). This provides a sufficient pool of treatment homes for matching purposes and a critical mass of individuals to provide needed expertise and to enhance the development of team work and mutual support. Programs serving more than 20 to 30 children may divide into teams, sometimes based upon geographic areas, to enhance management, supervision, and mutual support among staff (Meadowcoft, Luster, & Fabry, 1989).

Technical assistance from experienced programs can be extremely helpful to newly developing programs. Written materials such as procedure manuals and training materials can be purchased by new programs and adapted according to local needs, expertise, and preference; and ongoing technical support during early program operations can help to avoid many potential pitfalls (Davidson, Mayer, Gottschalk, Schmitt, Blakely, Emshoff, & Roitman, 1989). Some well-established programs offer such technical assistance and consultation. For example, People Places offers a technical assistance package covering an initial period of approximately six weeks that helps programs to develop operating policies and procedures, train staff, and train the first group of prospective treatment parents using the People Places curriculum. This initial consultation is followed by on-site visits for assistance and consultation during the early phases of program implementation (Snodgrass & Bryant, 1984).

To support program development efforts, several states have developed standards for therapeutic foster care programs. The North Carolina Department of Human Resources (1987) published a set of draft standards for therapeutic homes which address home capacity, designated qualified professionals, hours of operation, staff/client ratio, admission criteria, training of therapeutic parents, agreements with providers, coordination of treatment and education, role of parents, application for therapeutic parents, clinical consultation, daily activities, day program, housekeeping activities, and personal hygiene. Similarly, the Wisconsin Department of Health and Social Services (1989) promulgated a set of draft standards which may serve as the basis of future administrative rules for therapeutic foster care in the State. Among other requirements, the standards specify:

- No more than two children per home;
- Staff caseloads of no more than 12 children and their families;
- A minimum of one staff face-to-face contact per week with the child, treatment parents and natural family;
- A minimum of 20 hours preservice training and 14 hours inservice training per year for treatment parents;
- Treatment parents with at least a high school diploma and experience with children in some capacity;
- A minimum of 14 days per year of respite care for treatment parents;
- Daily written behavioral records on each youth placed in the home;
- No externally imposed or artificial limits on the length of treatment foster care placements; and
- Voluntary placement agreements.

Accumulating evidence points to a growing interest in therapeutic foster care and a surge in the development of these services beginning within the past several years (Webb, 1988; Meadowcroft, 1988). Data from the survey conducted by Snodgrass and Bryant (1989) revealed that many of the respondent programs were relatively new and suggested an increasing rate of new program development over time. The proliferation of therapeutic foster care services has been encouraged by ideological, programmatic, fiscal, and legal trends which have converged to stimulate experimentation with new, less restrictive, community-based models of care and treatment (Davidson, et al., 1989). Pilot programs have been developed in many states and communities to test program models and to evaluate program effectiveness.

Despite the rapid growth of therapeutic foster care programs and increasing excitement about the approach, some state administrators and legislators remain reluctant to fully endorse the concept or embark upon large-scale program development initiatives. This may be due, in part, to the fact that therapeutic foster care is a relatively new treatment modality with limited research data to substantiate its effectiveness. The problem may be compounded by a reluctance on the part of policy makers to exceed caps on regular foster care expenditures or to appropriate additional funds for therapeutic foster care (Welkowitz, 1987). Educational efforts regarding the value and effectiveness of therapeutic foster care and its potential role in an overall system of care will likely be necessary in order to increase both understanding and acceptance among key decision makers and to expand beyond the pilot phase.

Encouragement for the development of therapeutic foster care services has come from the Office of Human Development Services (HDS) of the U.S. Department of Health and Human Services (Federal Register, 1987). Grant support was available during fiscal year 1988 for demonstration programs which combined the various characteristics of therapeutic foster care such as increased payment rates, according treatment parents status as partners in service delivery, providing extensive training to treatment parents, enlarging the support services available to assist treatment families, and developing treatment parent support groups. Four such demonstrations were funded in Connecticut, Oregon, Missouri, and the District of Columbia.

Evidence of the growing interest in therapeutic foster care also can be found in the increasing number of conferences held around the country to educate providers about the approach. The Lee Mental Health Center has organized several conferences in Florida which are designed to provide information about therapeutic foster care and assist participants with their own program development activities. Several state mental health agencies, such as the Vermont Department of Mental Health, have sponsored conferences on providing therapeutic foster care services for emotionally disturbed children which address clinical, programmatic, and interagency issues.

Networking attempts among therapeutic foster care providers also are increasing, with the goal of sharing ideas and problems and providing mutual support. In Florida, a consistent effort has been made to organize therapeutic foster care programs into a cohesive network, with regular meetings including all programs within the state for purposes of mutual assistance and support (Friedman, 1983). In recognition of the fact that programs often struggle with their problems in relative isolation, Dr. James Brieling of the NIMH Center for the Study of Violent and Antisocial Behavior assisted in early efforts to bring programs together. Meetings involving programs from Virginia, North Carolina, and Pennsylvania were organized to share experiences and data (Bryant & Snodgrass, 1989).

From these early networking efforts evolved a series of national conferences and networking activities. The first national conference on therapeutic foster care was held in 1985 and was sponsored by Professional Parenting in North Carolina; 150 people representing approximately 35 states attended. The First North American Conference on Treatment Foster Care was held in Minneapolis in 1987, and the Second North American Conference was held in Calgary, Alberta, Canada in 1988. Attendance at the Minneapolis and Calgary conferences grew to more than 400; the 1989 conference will be held in Atlanta.

Largely as a result of the conferences, activities have begun to develop a national association to focus on therapeutic foster care. The association, currently called the Foster Family-based Treatment Association (FFTA), is conceived as a more formalized network to unite programs and individuals who are engaged in or supportive of therapeutic foster care. The role of the FFTA would include sponsoring conferences, publishing a newsletter, disseminating information and research, networking and linking programs both nationally and internationally, and advocating on a national level. A steering committee was established as a first step toward forming the FFTA and a survey was distributed to assess interest in forming an association. The FFTA, currently based in Minneapolis, has incorporated, established a fully constituted Board of Directors, launched a charter membership drive, and established short- and long-term goals to guide its efforts.

In order to enhance the development of therapeutic foster care services, improved evaluative research is needed, coupled with sustained efforts to involve and educate professionals and policy makers regarding the approach (Friedman, 1989). The continuing growth and expansion of the model in the coming years has been predicted, particularly as a service for children who currently are placed in the more restrictive settings of group homes and residential treatment centers (Snodgrass & Bryant, 1989).

As these services multiply, it is important to recall that therapeutic foster care is only one component of a comprehensive system of services needed for troubled children and their families. Emotionally disturbed children and their families should have access to intensive nonresidential service approaches before out-of-home treatment is considered; with high quality outpatient treatment, home-based services, day treatment, and crisis services, the need for any out-of-home placement often can be averted (Stroul & Friedman, 1986). Home-based services have been found to be highly effective in preserving family integrity and preventing unnecessary out-of-home placement (Stroul, 1988). These intensive, multifaceted interventions are designed to strengthen the family's coping skills and to link the child and family with appropriate community resources for ongoing services and support. Many states and communities have found home-based services to be effective gate-keeping mechanisms, ensuring that youngsters are not referred for out-of-home services unnecessarily. Friedman (1989) emphasized the importance of vigilance in making out-of-home placements to ensure that all possible nonresidential alternatives are tried first.

Therapeutic foster care might be one of the first options considered when it is clear that out-of-home treatment of some type is appropriate. Evidence increasingly indicates that the more normative family environments offered by treatment homes can substitute, in many cases, for the more restrictive treatment environments of group homes, residential treatment centers, hospitals, and training schools. However, therapeutic foster care and other forms of residential treatment should not be viewed as competing but rather as complementary. The use of therapeutic foster care will not eliminate the need for the other residential components of the system of care. Rather, the availability of therapeutic foster care will ensure that children are not placed in more restrictive settings than they actually need.

Thus, therapeutic foster care should be seen as one essential component of a comprehensive, balanced system of care, with all of the components dedicated to supporting and assisting children and families to the greatest possible extent and to ensuring that troubled children receive services within the least restrictive, most normative environment that is clinically appropriate. Within the context of the system, therapeutic foster care provides the residential treatment option that is least restrictive, most normalized, most family-oriented, and most flexible. As such, therapeutic foster care potentially can fulfill a vital role within a comprehensive system of care for seriously emotionally disturbed children and adolescents.

REFERENCES

Almeida, M.C., Hawkins, R., Meadowcroft, P., & Fabry, B. (1988). A comparison of PRYDE, a therapeutic foster care program, with alternative programs. Presented at Children's Mental Health Services and Policy: Building a Research Base, Tampa, FL.

Almeida, M.C., Meadowcroft, P., Hawkins, R.P., & Luster, W.C. (1989, February). Evaluation of foster family-based treatment in comparison with other programs: A preliminary analysis. Presented at the NATO Advanced Research Workshop on State Intervention on Behalf of Children and Youth, Acquafredda di Maratea, Italy.

Ambinder, W., & Falik, L. (1966). Keeping emotionally disturbed children in school. Children, 13 (6), 227-231.

Ambinder, W., & Sargent, D. (1965). Foster parents techniques of management of preadolescent boys' deviant behavior. Child Welfare, 44 (2), 90-94.

Barnes, K. (1980). Individualized model for specialized foster care for "hard to place" juvenile offenders. Washington, DC: The National Center on Institutions and Alternatives.

Bauer, J., & Heinke, W. (1976). Treatment family care homes for disturbed foster children. Child Welfare, 55 (7), 478-490.

Bedford, L., & Hyberston, L. (1975). Emotionally disturbed children: A program of alternatives to residential treatment. Child Welfare, 54 (2), 109-115.

Beggs, M. (1987). Foster families as partners in therapy. Four therapeutic foster care programs in the Bay Area. San Francisco, CA: San Francisco Study Center, Zellerbach Family Fund.

Bryant, B. (1980a). Special foster care: A history and rationale. Verona, VA: People Places.

Bryant, B. (1980b). Training specialized foster parents. In Specialized Foster Care: An Overview Workshop. Staunton, VA: People Places.

Bryant, B. (1981). Special foster care: A history and rationale. Journal of Clinical Child Psychology, 10 (1), 8-20.

Bryant, B. (1983). Special foster care: Evaluation of an alternative to institutions for disturbed children. Unpublished master's thesis, University of Virginia, Department of Government and Foreign Affairs, Charlottesville.

Bryant, B., Simmons, Fl, & McKee, M. (1987). Doing it in public: A review of foster family treatment program development in Missouri. Paper presented at the First North American Conference on Treatment Foster Care, Minneapolis, MN.

Bryant, B., & Snodgrass, R. (1989). Therapeutic foster care: Past and present. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Bryant, B., Snodgrass, R., Houff, J., Kidd, J., & Campbell, P. (1986). The parenting skills training. Staunton, VA: People Places.

Burge, D., Fabry, B., & James, J. (1987, August). Meeting the challenge: Treating diverse and difficult problems in therapeutic foster families. In M.C. Almeida (Chair), Foster parents as treatment agents. Symposium conducted at the Convention of the American Psychological Association, Washington, DC.

Carros, T., & Krikston, D. (1989). A public child welfare agency perspective on special foster care and foster family-based treatment. In R.P. Hawkins & J. Breiling (Eds.), Therapeutic foster care: Critical issues. Washington, DC: Child Welfare League of America.

Chamberlain, P. (1988). The use of trained nonprofessionals in providing therapeutic foster homes for state hospital mentally and emotionally disturbed youth. Final report to U.S. Department of Health and Human Services (Grant No. 90 C W0803/01). Eugene, OR: Oregon Social Learning Center.

Conway, R., Hawkins, R., & Fabry, B. (1988). Remedial training of professional treatment parents using video-assisted simulation and coaching to criterion. Paper presented at the Association for Behavior Analysis meeting, Philadelphia, PA.

Cox, R., & Cox, M. (1989). Application of lessons from foster care research to the evaluation of foster family-based treatment. Unpublished paper. Austin, TX: University of Texas, Health Science Center.

Coyne, A. (1978). Techniques for recruiting foster homes for mentally retarded children. Child Welfare, 57 (2), 123-131.

Daly, D. (1989). Ensuring quality child care and treatment through the program-specific training and supervision of personnel. In R.P. Hawkins & J. Breiling (Eds.), Therapeutic foster care: Critical issues. Washington, DC: Child Welfare League of America.

Davidson, W., Mayer, J., Gottschalk, R., Schmitt, N., Blakely, C., Emshoff, J., & Roitman, D. (1989). The dissemination of specialized treatment in foster care: Implications from the research literature. In R.P. Hawkins & J. Breiling (Eds.), Therapeutic foster care: Critical issues. Washington, DC: Child Welfare League of America.

Davis, D., Jemison, E., Rowe, M., & Sprague, D. (1984). Cluster homes: An alternative for troubled youths. Children Today, 13 (1), 34-37.

DeFries, Z., Jenkins, S., & Williams, E. (1965). Foster family care for disturbed children: A nonsentimental view. Child Welfare, 44 (2), 73-83.

Eastman, K.S. (1982). Foster parenthood: A nonnormative parenting arrangement. Marriage and Family Review, 5 (2), 95-120.

Engel, J. (1983). The parent therapist program: A new approach to foster care of difficult adolescents. Children and Youth Services Review, 5 (2), 195-207.

Federal Register. (1987, December). Methods and practices to recruit and retain family foster homes, 52 (250), 49277.

Fine, R. (1966). Moving emotionally disturbed children from institution to foster family. Children, 13 (6), 221-226.

Fine, G., & Friesen, B. (1988, December). Relinquishing custody as a means of obtaining services. Presentation at Next Steps: A National Family Agenda for Children Who Have Emotional Disorders, Arlington, VA.

Focus FFTA. (Fall, 1989). Foster Family-based Treatment Association newsletter, 1 (1). Minneapolis, MN.

Friedman, R. (1980). Therapeutic foster homes in Florida: A status report. Tampa: Florida Mental Health Institute; Child, Adolescent and Community Program.

Friedman, R. (1981). Therapeutic foster homes in Florida: A mid-1981 status report. Tampa: Florida Mental Health Institute; Child, Adolescent and Community Program.

Friedman, R. (1983). Therapeutic foster homes in Florida: A mid-1982 status report. Tampa: Florida Mental Health Institute; Child, Adolescent and Community Program.

Friedman, R. (1989). The role of therapeutic foster care in an overall system of care: Issues in service delivery and program evaluation. In R.P. Hawkins & J. Breilina (Eds.), Therapeutic foster care: Critical Issues. Washington, DC: Child Welfare League of America.

Friedman, R., & Zeigler, C. (1979). Therapeutic foster homes: An alternative residential model for emotionally disturbed children and youth. Tampa: Florida Mental Health Institute; Child, Adolescent and Community Program.

Gedeon, S. (1986). Parent Therapist Program. Presented at "Claiming the Unclaimed Children" Conference. Boulder, CO.

Gold Award (1977). Institutions without walls for emotionally disturbed children. Chedoke Child and Family Centre, Hamilton, Ontario. Hospital and Community Psychiatry, 28 (11), 849-851.

Goldman, S. (1988). Series on community-based services for children and adolescents who are severely emotionally disturbed. Volume II: Crisis services. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Goldstein, H., Gabay, D., & Switzer, R. (1981). "Failsafe" foster family care: A mental hospital-child welfare agency program. Child Welfare, 60 (9), 627-636.

Gray, B. (1957). A foster family program for disturbed children. Child Welfare, 36, 10-15.

Grealish, E.M., Hawkins, R.P., Meadowcroft, P., & Lynch, P. (1989). Serving families of children in therapeutic foster care. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Grealish, E.M., Hunt, J., James, J., & Lynch, P. (1987, September). Professional parent recruitment: Effective methods for family-based treatment programs. In J. Baker (Chair), Foster family-based treatment. Symposium conducted at the Southeastern Psychological Association Convention, Atlanta, GA.

Grealish, E.M., & Meadowcroft, P. (1989). Referring to and placing children in therapeutic foster homes. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Gross, N., & Campbell, P. (1989). Recruiting and selecting treatment foster parents. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Hampson, R. (1975). Selecting and training foster parents as therapists: Community care for handicapped children. Unpublished master's thesis, University of Virginia, Charlottesville.

Hampson, R. (1988). Special foster care for exceptional children: A review of programs and policies. Children and Youth Services Review, 10, 19-41.

Hawkins, R. (1987, August). What is this thing? Defining foster care, special foster care and foster family-based treatment. Paper presented at the First North American Treatment Foster Care Conference, Minneapolis, MN.

Hawkins, R. (1989). The nature and potential of therapeutic foster family care programs. In R.P. Hawkins & J. Brieling (Eds.), Therapeutic foster care: Critical issues. Washington, DC: Child Welfare League of America.

Hawkins, R., Almeida, M.C., Meadowcroft, P., Fabry, B., & Luster, W.C. (1988, March). Second quarterly report to the Buhl Foundation regarding evaluation of foster family-based treatment. Pittsburgh: The Pressley Ridge School.

Hawkins, R., & Breiling, J. (1989). (Eds.). Therapeutic foster care: Critical issues. Washington, DC: Child Welfare League of America.

Hawkins, R., & Luster, W.C. (1982, August). Family-based treatment: A minimally restrictive alternative with special promise. In E.L. Phillips (Chair), Behavioral treatment of youth in professional foster homes. Symposium conducted at the Convention of the American Psychological Association, Washington, DC.

Hawkins, R., & Meadowcroft, P. (1982). Practical program evaluation in a family-based treatment program for disturbing and disturbed youngsters. Pittsburgh: The Pressley Ridge School.

Hawkins, R., Meadowcroft, P., Trout, B., & Luster, W.C. (1985). Foster family-based treatment. Journal of Clinical Child Psychology, 14 (3), 220-228.

Hawkins, R., Peterson, R., Schweid, E., & Bijou, S. (1966). Behavior therapy in the home: Amelioration of problem parent-child relations with the parent in a therapeutic role. Journal of Experimental Child Psychology, 4 (1), 99-107.

Hazel, K.N. (1982). New hope for the teenage outcast. International Journal of Offender Therapy and Comparative Criminology, 26 (1), 62-71.

Hensley, E.B. (1986). Mentor. Boston, MA: National Mentor, Inc.

Horejsi, C., Bertsche, A.V., & Clark, F. (1981). Social work practice with parents of children in foster care. Springfield, IL: Charles C. Thomas.

Johnston, E., & Gabor, P. (1981). Parent counselors: A foster care program with new roles for major participants. In A. Maluccio & P. Sinanoglu (Eds.), The challenge of partnership: Working with parents of children in foster care. New York: Child Welfare League of America.

Jones, R. (1989). Evaluating therapeutic foster care. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Jones, R., Weinrott, M., & Howard J. (1981). The national evaluation of the Teaching-Family model. Rockville, MD: National Institute of Mental Health, Center for Studies of Crime and Delinquency.

Kirigin, K., Braukmann, C., Atwater, J., & Wolf, M. (1982). An evaluation of Teaching-Family (Achievement Place) group homes for juvenile offenders. Journal of Applied Behavior Analysis, 15, 1-16.

Knickerbocker, D., & Langford, V. (1978). Family re-ed project: A mental health foster parent network for emotionally disturbed adolescents. In Programs for dependent adolescents: Issues, problems, alternatives. Conference proceedings. Tampa: Florida Mental Health Institute; Child, Adolescent and Community Program.

Knitzer, J. (1982). Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services. Washington, DC: Children's Defense Fund.

Lahti, J., & Dvorak, J. (1981). Coming home from foster care. In A. Maluccio & P. Sinanoglu (Eds.), The challenge of partnership: Working with parents of children in foster care. New York: Child Welfare League of America.

Lanier, J., & Coffey, J. (1981). Therapeutic homes: A treatment alternative to foster care. Journal of Clinical Child Psychology, 10 (1), 48-50.

Larson, G., Allison, J., & Johnston, E. (1978). Alberta parent couselors: A community treatment program for disturbed youths. Child Welfare, 57 (1), 47-52.

Levin, S., Rubenstein, J., & Streiner, D. (1976). The parent-therapist program: An innovative approach to treating emotionally disturbed children. Hospital and Community Psychiatry, 27 (6), 407-410.

Maluccio, A. (1966). Selecting foster parents for disturbed children. Children, 13 (2), 69-74.

Maluccio, A. (1981). An ecological perspective on practice with parents of children in foster care. In A. Maluccio & P. Sinanoglu (Eds.), The challenge of partnership: Working with parents of children in foster care. New York: Child Welfare League of America.

Maluccio, A., & Sinanoglu, P. (Eds.) (1981). The challenge of partnership: Working with parents of children in foster care. New York: Child Welfare League of America.

Maluccio, A., & Whittaker, J. (1989). Foster family-based treatment and special foster care: Implications for parental involvement. In R.P. Hawkins & J. Breiling (Eds.), Therapeutic foster care: Critical issues. Washington, DC: Child Welfare League of America.

Maryland Department of Human Resources. (1987). Specialized foster care. Baltimore, MD: Department of Fiscal Services.

McManus, M., & Friesen, B. (1989). Relinquishing legal custody as a means of obtaining services for children who have serious mental or emotional disorders. Testimony presented to the U.S. House of Representatives, Sub-committee on Human Resources, Committee on Ways and Means, Washington, DC.

Meadowcroft, P. (1988). Troubled youth in treatment homes. Pittsburgh, PA: The Pressley Ridge Schools.

Meadowcroft, P., & Grealish, E.M. (1989). Training and supporting treatment parents. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Meadowcroft, P., Hawkins, R.P., Grealish, E.M., & Weaver, P. (1989). Providing services to children in therapeutic foster care. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Meadowcroft, P., & Luster, W.C. (1989). Realizing the potential of therapeutic foster care. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Meadowcroft, P., Luster, C., & Fabry, B. (1989). Professional staff and organizational structures. In P. Meadowcroft & B. Trout (Eds.), Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Meadowcroft, P., & Trout, B. (Eds.). (1989). Troubled youths in treatment homes: A handbook of therapeutic foster care. Washington, DC: Child Welfare League of America.

Mora, G. (1962). Foster families for emotionally disturbed children. Child Welfare, 41 (3), 104-106.

North Carolina Department of Human Resources. (1987). Individualized residential treatment for emotionally disturbed children: An implementation guide. Raleigh, NC: Division of Mental Health, Mental Retardation and Substance Abuse Services.

Parent Therapist Program. (1988). Presentation at CASSP Training Institutes on Community-Based Services for Severely Emotionally Disturbed Children and Youth, Boulder, CO.

Penn, J. (1978). A model for training foster parents in behavior modification techniques. Child Welfare, 57 (3), 175-180.

Rice, D., & Semmelroth, S. (1968). Foster care for emotionally disturbed children. American Journal of Orthopsychiatry, 38, 539-542.

Roe, S. (1988). Treatment families program. Final report to U.S. Department of Health and Human Services. Norwich, CT: Department of Children and Youth Services.

Rubenstein, J., Armentrout, J., Levin, S., & Herald, D. (1978). The parent-therapist program: Alternative care for emotionally disturbed children. American Journal of Orthopsychiatry, 48 (4), 654-662.

Russell, T., & Silberman, J. (1979). Improving the delivery of specialized foster care services. Social Casework, 60 (7), 402-407.

Ryan, P., McFadden, E., & Warren, B. (1981). Foster families: A resource for helping parents. In A. Maluccio & P. Sinanoglu (Eds.), The challenge of partnership: Working with parents of children in foster care. New York: Child Welfare League of America.

Seaberg, J. (1981). Foster parents as aids to parents. In A. Maluccio & P. Sinanoglu (Eds.), *The challenge of partnership: Working with parents of children in foster care*. New York: Child Welfare League of America.

Sinanoglu, P. (1981). Working with parents: Selected issues and trends as reflected in the literature. In A. Maluccio & P. Sinanoglu (Eds.), *The challenge of partnership: Working with parents of children in foster care*. New York: Child Welfare League of America.

Snodgrass, R. (1977). *Specialized foster care: A model for serving handicapped children*. Presented at the Virginia State Federation Council for Exceptional Children, Roanoke, VA.

Snodgrass, R. (1988). *Therapeutic foster care*. Presented at "Investing in Virginia's Future: A Continuum of Care for our Adolescents at Risk," Viginia Beach.

Snodgrass, R., & Bryant, B. (1984). *Special foster care: Past and present*. Staunton, VA: People Places.

Snodgrass, R., & Bryant, B. (1989). Special foster care and foster family-based treatment: A national program survey. In R.P. Hawkins & J. Breiling (Eds.), *Therapeutic foster care: Critical issues*. Washington, DC: Child Welfare League of America.

Snodgrass, R., & Campbell, P. (1979). *Computer assisted matching of special needs children with teaching "foster" parents*. Paper presented at the Virginia State Federation Council for Exceptional Children, Roanoke, VA.

Snodgrass, R., & Campbell, P. (1981). *Specialized foster care: A community alternative to institutional placement*. Staunton, VA: People Places.

Stepleton, S. (1987, March-April). Specialized foster care: Families as treatment resources. *Children Today*, *16* (2), 27-31.

Stroul, B. (1988). *Series on community-based services for children and adolescents who are severely emotionally disturbed. Volume I: Home-based services*. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Stroul, B., & Friedman, R. (1986). A system of care for severely emotionally disturbed children and youth. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Teaching Research. (1986). *Teaching Research Infant and Child Center Newsletter*, *14* (2): Monmouth, OR.

Timbers, G. (1989). Client characteristics and the durability of their placements in treatment homes. In P. Meadowcroft & B. Trout (Eds.), *Troubled youths in treatment homes: A handbook of therapeutic foster care*. Washington, DC: Child Welfare League of America.

Treatment Foster Care Association. (1988, April). *Treatment Foster Care Association Newsletter*. Staunton, VA: People Places.

Update. (1986). Program update: Therapeutic foster care. *Update - Improving Services for Emotionally Disturbed Children*, *2* (1). Tampa: Florida Mental Health Institute, University of South Florida.

Van Den Brink, S. (1984, March-April). Expanding the options for disturbed youth and their families. *Children Today, 13* (2), 32-35.

Walkind, S. (1978). Fostering the disturbed child. *Journal of Child Psychology and Psychiatry,* 19, 393-397.

Waskowitz, V. (1954). Foster family care for disturbed children. *Children, 1* (4), 125-130.

Watson, K. (1982). A bold new model for foster family care. *Public Welfare, 40* (2), 14-21.

Webb, D. (1988). Specialized foster care as an alternative therapeutic out-of-home placement model. *Journal of Clinical Psychology, 17* (1), 34-43.

Welkowitz, J. (1987). *A report on therapeutic foster care*. Waterbury, VT: Department of Mental Health, Child and Adolescent Service System Program.

Whittaker, J. (1981). Family involvement in residential treatment: A support system for parents. In A. Maluccio & P. Sinanoglu (Eds.), *The challenge of partnership: Working with parents of children in foster care*. New York: Child Welfare League of America.

Whittaker, J., & Maluccio, A. (1989). Changing paradigms in residential services for disturbed/disturbing children: Retrospect and prospect. In R.P. Hawkins & J. Breiling (Eds.), *Therapeutic foster care: Critical issues*. Washington, DC: Child Welfare League of America.

Wildy, L. (1962). The professional foster home. In *Foster family care for emotionally disturbed children: A compilation of ten published papers*. New York: Child Welfare League of America.

Wisconsin Department of Health and Social Services. (1989). *Final report of the treatment foster care task force*. Madison, WI: Division of Community Services, Bureau for Children, Youth and Families.

Witters, D., & Snodgrass, R. (1982). *The past, present and future of therapeutic foster care at People Places, Inc. and elsewhere*. Paper presented at the symposium on Youth Treatment in the Natural Environment: Developing Foster Family-Based Alternatives at the Eighth Annual Convention of the Association of Behavioral Analysis.

III. PROGRAM DESCRIPTIONS

FAMILY NETWORK PROGRAM
THERAPEUTIC FOSTER CARE AND INDIVIDUAL RESIDENTIAL TREATMENT
LEE MENTAL HEALTH CENTER
FORT MYERS, FLORIDA

History

The Family Network Program operated by the Lee Mental Health Center is a therapeutic foster care program providing family-based treatment and a network of community supports. The program serves emotionally disturbed children and adolescents who require placement outside their homes and are at risk for more restrictive care or who are returning to the community from more restrictive residential treatment settings. The program provides two "levels" of care. Level I is termed "Therapeutic Foster Care," and a more intensified version of the program which serves more severely disturbed youngsters is termed "Individual Residential Treatment."

The program was developed in 1976 when there were few treatment resources for troubled children in the Lee County area. The Director of Children's Services and the director of a group home at the Lee Mental Health Center recognized serious problems with the treatment provided in the group home setting. The group home was characterized by a hostile environment with negative peer models, often creating a "chain reaction" of disturbed behavior among residents. The directors attempted to design a treatment approach that would eliminate some of the problems inherent in the group home environment. Although they were unaware of other therapeutic foster care models at the time, they decided to place troubled youngsters in healthy home environments and to provide treatment and a range of community services and supports in this context, thereby founding the Family Network Program.

The program was started with grants from the State of Florida and began with one staff person and six youngsters. Expansion was gradual, with the addition of staff and children as funding increased. Currently, the program is comprised of approximately 30 beds in Therapeutic Foster Care and 10 to 12 beds in Individual Residential Treatment (IRT). The program has been pressured to expand both components, particularly IRT, but feels that an essential ingredient would be lost if it becomes too large.

The roots of the IRT component can be traced to the recognition that many children who were placed in psychiatric hospitals could be treated in the community with an intensified service approach. A 1984 survey of children in state hospitals conducted by the Florida Mental Health Institute revealed that, in many cases, children are placed in expensive and highly restrictive treatment settings not because of the nature or severity of their emotional disorders but because of gaps in the service system. The Director and staff of the Family Network Program hypothesized that some youngsters need more support than can be provided in therapeutic foster homes, but, with intensive support and guidance, can be prevented from entering residential treatment facilities. They felt that these youngsters would be able to function in the community with intensive one-on-one services within a specialized family unit that is provided with extensive training and support.

Accordingly, the Lee Mental Health Center initiated a pilot project in 1985 which involved serving one severely emotionally disturbed youth in a treatment home. The specialized treatment parent was paid significantly more, and was responsible for providing one-to-one care and supervision 24 hours a day. The success of this pilot project led to the establishment of the IRT component, which currently is described as enriched or intensified therapeutic foster care, serving youngsters who otherwise would be placed in institutional treatment environments. Treatment parents are paid more than those in the therapeutic foster care component since caring for the child is considered a full-time job; one parent is required to be at home at all times and cannot have any employment outside the home. In addition to the enhanced financial support, the IRT program involves enhanced staff support and "wrap-around" services.

Community and Agency Context

The Family Network Program primarily serves Lee County, the catchment area for the Lee Mental Health Center. Lee County, located in the southwest part of Florida, has a population of approximately 300,000. The population of Lee County is growing rapidly and, in fact, has doubled over the last decade. As is the case in many Florida counties, the vast population growth is largely attributable to a continuing influx of northerners who are settling in the state. With respect to population, the Lee County area is one of the most rapidly growing areas in the United States. The population growth has created an accompanying growth in the demand for all types of community services.

While Lee County has a sizeable population of retired and elderly persons, the population growth is not limited to this group. The influx of residents includes younger families as evidenced by the increases in school-aged children in the area. Approximately two new schools have opened each year to keep pace with the need, including two new high schools which opened in 1987.

The community is characterized as mixed. Fort Myers, the county seat, and Cape Coral are the two major urban population centers, with the surrounding areas being primarily rural. The county encompasses coastal areas as well as a number of barrier islands such as Sanibel, Captiva, and others. The community is largely middle class, with the primary sources of employment being tourism and agriculture. The population is predominantly white; approximately 14 percent of the population is minority, mostly black with a smaller proportion of Hispanics.

At the request of the Florida Department of Health and Rehabilitative Services (HRS), the Family Network serves several neighboring counties on a limited basis. If space is available, the program serves youngsters from nearby counties including Charlotte, Henry, Glades, and Collier Counties. While services are provided to neighboring counties, the program is committed to remaining community-based and resists serving children from more distant areas. Staff have provided consultation and technical assistance to other counties to assist them in developing their own programs within their own communities. With such assistance, a new therapeutic foster care program was started within Collier County in 1988, easing dependence upon the Lee County resource.

The Lee Mental Health Center is a comprehensive community mental health center with an overall budget exceeding $6.7 million. Like its catchment area, the Center also has grown considerably over the past decade, progressing from 30 employees to more than 200 employees today. While many mental health centers around the country have been beset by budget cuts and reductions in services, the Lee Mental Health Center has grown steadily and has not sustained any major cutbacks. At one time, Center programs were scattered among multiple sites. However, the Center acquired a large tract of land and constructed a large complex of buildings in 1981. Most Center programs now are consolidated on this campus. Satellite offices are located in two of the more populated areas of the county, Cape Coral and Lehigh Acres.

The Center consists of several major components: Adult Services including outpatient, psychiatric, and psychological services and a gerontology program; Adult Residential Treatment consisting of case management for all adults who have been in state hospitals, group homes, day treatment, social and vocational programs and a range of residential options; Crisis Services including a 28-bed Crisis Stabilization Unit providing short-term acute treatment as an alternative to hospitalization; and Drug Abuse/Criminal Justice Services which include a variety of substance abuse treatment services and a forensic program. Children's Services is another major component. The Center has been successful in obtaining grant funds to support children's services and reportedly has more children's programs than many other mental health centers in Florida. The Family Network Program falls within the Children's Services Unit as well as the following services:

- Outpatient Services - Outpatient services for children and families including individual and family therapy, psychiatric services, and psychological services.
- Abuse and Neglect Prevention Services - Consultation and education services in the community directed toward training professionals to identify signs of physical, sexual, and emotional abuse among children.
- Project PREVENT - Specialized services for preschool children diagnosed with behavior problems and attention deficit disorders.
- Intensive Crisis Counseling Program (ICCP) - Home-based services designed to intervene in crisis situations to prevent removal of children from their families. The intervention is based upon the Homebuilders model and provides intensive services over a six-week period.
- Therapeutic Outreach Program (TOP) - Longer-term, home-based services which involve providing individual and family therapy on an outreach basis for an average of two to four months, or longer if necessary.
- CLASS Program - Provides staff to work collaboratively with schools on behalf of emotionally disturbed children. Staff go into the schools to support teachers, implement home and school behavior management programs, promote home-school collaboration, engage in psycho-educational activities with individual children, attend child study team meetings, and provide behavioral and mental health consultation.
- Parent Education - A series of classes on parenting skills offered during daytime and evening hours. Parents may participate voluntarily or may be court-ordered to participate.
- Cocaine Babies - A new intervention program designed to serve cocaine babies and their parents.

The Family Network Program, as well as other children's services, enjoy active and positive support from the Center's administration. The Center Director is interested in children's issues and consistently has supported the growth of children's programs within the Center. Additionally, Center leadership is perceived as committed and responsive to the needs of the Family Network Program, with ample opportunities provided to voice concerns. On a monthly basis, the Center Director meets individually with each Program Director. Through this mechanism, the Director of the Family Network Program has frequent interchanges with the Center Director to identify problem areas and needs, to be kept informed about events and issues affecting the overall Center, and to provide direct input into decisions affecting the program's and Center's future.

The Lee Mental Health Center is governed by a 15-member Board of Directors. The Board is kept informed about Center programs but is not actively involved with the Family Network Program. On the whole, the program operates within the context of a large mental health center which is highly supportive of the Family Network Program and of children's mental health services in general.

Philosophy and Goals

The philosophy of the Family Network Program is based upon the use of a natural, healthy, family environment as the treatment milieu. The approach stems from the belief that children in residential treatment centers, group homes, hospitals, and the like learn how to adapt in artificial environments. In contrast, therapeutic foster care allows children to learn how to adapt in normal family, school, and community environments -- the same type of environments that they must function in over the long-term. Program leadership and staff strenuously express the belief that children should be removed from their natural families as a last resort only, and that every available intervention should be attempted first. However, a basic premise of the Family Network Program is that when removal from the natural family is necessary, therapeutic foster care offers the most normalized, productive treatment setting.

The treatment approach used by the Family Network Program is described as eclectic and capitalizes on the dynamics of each treatment home. The program does not subscribe to a behavioral or structured treatment model, but rather considers the milieu of the treatment family to be the major therapeutic agent, the catalyst which allows the child the change. The treatment parents are considered to be the most important members of the treatment team, and the relationships and interactions that develop within the treatment family are the most important ingredients of the intervention. The program asserts that many of the children served have had dysfunctional relationships in the past and that therapeutic foster care provides the opportunity to develop and maintain healthy relationships. The program strives to allow these relationships within the family and with staff flourish in a natural way, unencumbered by overly technical or structured treatment methods.

Thus, the program relies heavily on the overall therapeutic value of the treatment home environment in its approach. Each treatment home offers different dynamics, and the program attempts to capitalize on the strengths of each treatment family in designing its interventions. Specific treatment approaches (such as behavioral, Gestalt, and other techniques) are used when indicated, and all events and situations occurring in the natural environment are seen as therapeutic opportunities. Staff emphasize that the hallmark of therapeutic foster care is the ability to totally individualize services, from the selection of a treatment home for a particular child to the development of a treatment approach that is tailored to the child's needs.

The Family Network Program strives to achieve three major goals:

o To provide a therapeutic milieu in a healthy family.

o To prevent institutionalization.

o To act as a transition back into the community for children in institutions.

The first goal addresses the treatment philosophy of the program. The intervention is directed as "re-educating" the child with the positive interactions and reinforcements provided in a healthy, family environment. The program elaborates that this goal includes providing treatment to both the child and the natural family, with the ultimate objective of reuniting the child with the family. When reunification is not realistic, the program endeavors to provide a permanent placement for the child.

The second goal reflects the program's commitment to preventing institutionalization to the extent possible. It is acknowledged that some children require institutional care, at least for short periods of time. However, the experience of the program is that it can work with more severely disturbed children than was initially predicted. The IRT program, in particular, is designed to work with the most severely disturbed youngsters with the goal of preventing hospitalization.

The third programmatic goal addresses the needs of children already in institutional treatment settings. Many are not ready to return directly home upon discharge and, for other children, the length of stay in residential treatment settings can be reduced significantly with the continued treatment provided in therapeutic foster care. Thus, the program strives to reduce institutionalization by serving as a "community feedback resource."

Services

Preplacement Phase - The preplacement phase of services begins with a referral to the program. The vast majority of referrals (as much as 90 percent) to the Family Network Program come from HRS, Florida's child welfare agency. Of these referrals, approximately three-quarters represent children who are adjudicated dependent on HRS due to child abuse or neglect. Small numbers of referrals (perhaps 5 percent) emanate from other units of the Lee Mental Health Center, with the remaining referrals originating with a conglomeration of other agencies including the schools, courts, and, in some cases, parents.

The next step in the preplacement process involves a formal review of all referrals by the district's Case Review Committee (CRC). Florida regulations require that, in each district, a multidisciplinary committee screens and reviews all children from the district who are thought to need therapeutic placements outside the home. In the Lee County district, the CRC consists of 10 professionals including the Director of the Family Network Program and the Director of Children's Services from the Lee Mental Health Center.

The referring individual is required to contact the chairperson of the CRC and to prepare a packet of information on the child for the committee members to review. Typically, the case is presented to the committee by the case manager, and anyone who is interested or involved with the case is encouraged to attend the staffing, including the child's parents or guardians, HRS caseworker, private therapist, and school personnel. Based upon the information presented, and any additional testing or data that may be requested, the CRC makes a decision regarding the most appropriate placement for the child.

In addition to its role in screening, the CRC is responsible for reviewing the progress of children in out-of-home, therapeutic placements. This is done on a regular basis, with a full committee review of each child every three months. The CRC in the Lee County district is strongly guided by the concept of "least restrictive environment." With vigorous screening of referrals and frequent review of children in out-of-home placements, the committee has been instrumental in reducing the use of the state hospital for children and adolescents. Additionally, the committee has "purchase of service" funds at its disposal to pay for treatment services, including therapeutic foster care, needed by children who are not dependent upon the state.

Following approval by the CRC, a Family Network Program staff meeting becomes the structure used to continue the preplacement process. Staff review the information, and the case is assigned to a staff person who has room on his or her caseload and has an interest in the case. The staff meeting also is used to discuss potential matches for the child -- which treatment parents have space or are likely to have space in the near future and which treatment parents would provide the best placement for the particular child. When a potential placement is designated, the assigned clinician immediately becomes involved and initiates contact with the child, natural parents, and treatment parents.

The assigned clinician visits the potential treatment parents, spending a considerable amount of time with them and providing all available information on the child. Staff emphasize that it is essential for treatment parents to know "the whole picture" and to trust that no information about the child's history or problems will be withheld from them. In some situations, the program prefers to have treatment parents meet the child before reading detailed background information on the child. Because the referral information and background material often presents the child in the most negative light, meeting the child first may provide treatment parents with a more balanced perspective. The clinician also visits the natural parents to discuss the program, the transfer to the treatment home, and the involvement of natural families. A contact with the child also is arranged to familiarize him or her with the program and to encourage the child to "buy into" the treatment effort.

Preplacement visits are used for older children. Youngsters may visit the treatment home for a day or a weekend to allow them to learn about the structure and expectations and to experience family life in the home. When necessary, two or three preplacement visits may be arranged prior to the actual placement. Placement is made only when both the child and treatment parents feel ready to make a commitment to each other. This commitment is taken seriously, and the program discourages moves to other treatment homes once the initial placement is made. The program reports that it is rare for a youngster to reject a potential placement following a trial visit.

The norm for the Family Network Program is the placement of only one child in a treatment home. At the time of the site visit, however, there were five treatment homes with more than one child in placement. Placement of two children in a treatment home is considered by the program under certain clearly specified circumstances, such as when siblings require placement, when a child could benefit therapeutically by being placed with another child, or when treatment parents are so experienced and competent that they can work effectively with two children. Additionally, after nine or ten months in a treatment home a child may be stabilized and may provide a good role model for another child. In this situation, the program might consider placing a second child in the treatment home. The program attempts to place minority children with minority treatment families. The rationale for this policy is that, given the nature of the area, cross-racial placements may create neighborhood and other difficulties for the children.

The program has no waiting list, and, on the average, the preplacement process takes approximately two weeks. In a fair number of cases, the program can place a child within a day or two of the CRC staffing. However, the preplacement process may span a period of as much as two months if a child has particularly difficult needs or circumstances. On the agreed upon date of placement, the clinician picks up the child and brings him or her to the treatment home. The staff person stays for a period of time, ensuring that the child is beginning to feel comfortable before leaving.

Intervention Phase - Like other therapeutic foster care programs, the intervention phase of services consists of treatment within the treatment home, support services to the treatment home, a range of ancillary services, and services to natural parents. A preliminary treatment plan must be completed prior to placement, and a permanent treatment plan must be formulated within 30 days. While the program does not hold a large, formal meeting to develop the treatment plan, the clinician works closely with all involved persons to obtain their input. For example, the clinician meets with the school, natural parents, psychiatrist, and staff from other involved agencies to assist in formulating treatment goals and strategies. In collaboration with the treatment parents, the treatment plan is finalized. There is a requirement that all parties concerned with the case sign the treatment plan to indicate their agreement, including natural parents, treatment parents, clients, and referring agency.

Working closely with the treatment parents, the treatment plan and strategies are reviewed and revised regularly based upon the child's response and progress. This process occurs informally, based upon the frequent interactions between treatment parents and clinicians. The more formal process of reviewing and updating the official "treatment plan" is accomplished periodically, generally on a 60-day basis.

As noted previously, the treatment provided by the Family Network Program is based on the natural, free-flowing relationships that develop within the treatment family. The milieu of the healthy family environment is considered the major therapeutic agent, and the interactions and relationships within the family are the catalysts that allow the child to change. As a rule, the program does not employ structured treatment approaches, although staff report that their approach is eclectic and that they use anything that works in appropriate circumstances. In fact, each home may operate on a different system depending upon the strengths of the treatment parents and the individual needs of the child. According to program staff, one of the major advantages of the program is the ability to individualize the treatment approach based upon the needs of each child; a behavioral approach might be used with a young child, while a more insight-oriented, verbal approach might be used with an adolescent.

Much of the treatment provided by the program occurs in a casual, natural way within the treatment family and with staff. "Treatment" may take place during family activities, chores, or outings, and virtually any event occurring in the daily routine of family life can be seen and used as a therapeutic opportunity. The treatment team defined by the program includes the clinician, natural parents, HRS caseworker, and treatment parents. The treatment parents, however, are considered the most important members of the treatment team as they provide the therapeutic milieu and the vast majority of the treatment. Some of the general treatment objectives outlined by the program include helping children to express feelings better, improve their self-esteem, experience rewarding relationships, learn problem solving techniques, and develop internal discipline.

The treatment provided in the IRT program is considered more intensive. One treatment parent is required to be at home on a full-time basis, and caring for the child is considered a full-time job. Initially, one-to-one care and supervision are provided by the treatment parents 24 hours a day, with no unsupervised time for the child. As the child stabilizes, the level of supervision may become more flexible.

The program provides extensive support to treatment homes. Of primary importance is the support provided by clinicians. In the Therapeutic Foster Care component, the clinician visits each home at least once per week; in the IRT component, clinician visits occur a minimum of twice weekly. The visits may occur during evening hours or on weekends, as needed, and serve a variety of purposes. Staff may spend some time alone with the child, some time alone with treatment parents, and/or time together with the child and treatment parents. While the clinician provides "counseling," the staff visits also involve sharing concerns, reviewing problems, providing training, offering ideas and suggestions, providing support, or even mediating the structure and rules within the treatment home. The role of the clinician is to support and advise treatment parents, to assist them in their role as primary agents of treatment, and not to tell them what to do in an overly controlling or directive way. The relationship which evolves between the clinician and treatment parents is described as "human, intimate, and folksy." In addition to the home visits, phone contact between treatment parents and staff may occur twice a week or more frequently when necessary. Monthly inservice training sessions offer another important source of support for treatment parents.

Crisis assistance is available to treatment homes 24 hours a day. There is no rotational on-call system for the program, and staff do not carry pocket pagers. However, treatment parents are provided with the home telephone numbers of staff. If their own clinician is unavailable, treatment parents know the other staff members and feel free to call another staff person or the Program Director. Although the Lee Mental Health Center operates a 24-hour emergency service system, the Family Network Program rarely utilizes this service. Center staff are not familiar with the treatment parents or children, and crises are more effectively handled directly by program staff. According to both staff and treatment parents, someone can always be reached. Telephone consultation may be sufficient to support the treatment parents and assist them in handling the crisis, but, if necessary, the clinician goes to the treatment home to provide crisis intervention on-site.

The program has a written procedure for handling crises in which the child appears dangerous to himself or others. If possible, the treatment parents transport the child to the mental health center for assessment by a Family Network clinician and subsequently by a clinician from the Center's Crisis Stabilization Unit (CSU). If the child is too out of control for the treatment parents to transport, staff go immediately to the treatment home to make an assessment. If absolutely necessary, the assistance of law enforcement personnel is enlisted to transport the child to the Center where a CSU clinician conducts an assessment. While the CSU is primarily for adults, the child may be admitted for short-term stabilization in some circumstances. The written crisis guidelines clearly state that these procedures are to be used only as a last resort in extreme cases. The program reports that in more than a decade of operation, these emergency hospitalization procedures have been used for only 10 children. Program staff noted that because the program is accepting increasingly more disturbed and difficult youngsters in the IRT component, it is possible that the use of emergency procedures may increase.

In crisis situations, every attempt is made to keep the child within the treatment home. If the crisis results from a conflict between the youngster and treatment parents, staff attempt to help the family work through problems and keep their commitment to each other. Under very limited circumstances, consideration will be given to shifting the child to another treatment home. This decision is made only when it becomes clear that a good match was not made at the onset of services or if certain issues come to light that were unknown at the time of placement.

Incidents of running away inevitably occur among children in treatment homes. When this occurs, staff must be notified immediately. When the child is located or returns, he or she goes back to the same treatment home, thereby learning that they won't be rejected from the treatment home or the program by running away. The policy of the program is that runaways always are greeted with a show of concern and love (as well as with food and a shower), and the discipline issues are dealt with at a later time.

There have also been incidents of acting out, threatening, or violent behavior among youngsters in the program, although these are rare. No serious injuries to others have been caused by youngsters to date. Program staff attempt to be alert to developing crises and to intervene to defuse any potentially dangerous or explosive situations.

Respite services are not provided on a formal basis by the program. At one time, identified homes were available for respite purposes, but most of these homes ultimately opted for full-time children in placement. The program has moved to more informal arrangements for respite care. Treatment parents use their own friends and families or other treatment parents to provide respite for each other.

The program provides and arranges for a variety of ancillary services. In fact, staff indicate that one of the program's major assets is its ability to plug in additional resources and supports as needed for each individual child. Ancillary services may include:

- Mental Health Services - Additional mental health services represent one type of ancillary service that children may receive. While Family Network clinicians may provide counseling to youngsters, some are involved in therapy with other clinicians in the Lee Mental Health Center or in the community, particularly if a relationship with a therapist had been established prior to entering the program. Approximately, 20 percent of the children in the Family Network Program receive psychiatric services, generally involving ongoing follow-up by a psychiatrist at the Center. Some children are on psychotropic medications, and see a psychiatrist regularly for medication monitoring. At this time, approximately 43 percent of the children in the program are on some type of psychotropic medication; youngsters in the IRT program are more likely to require medication monitoring and other psychiatric services.

  Therapy groups also are offered for youngsters in the program when deemed appropriate. Psychological testing is another service of the Lee Mental Health Center that may be provided to youngsters in the Family Network Program when indicated.

- School Support - Extensive support and coordination with the schools is another adjunct service provided by the program. Included on the Family Network staff is a psycho-educational specialist who works closely with the schools serving youngsters in the program. Her primary objective is to help schools work more effectively with these youngsters, most of whom (approximately 60 percent) are in special education classrooms for "severely emotionally disturbed" or "emotionally handicapped" children. The psycho-educational specialist typically is involved with about 12 or 13 children, depending upon the need, and is considered a member of the treatment team for each youngster. She spends an average of two hours per week per child in the school consulting with the teacher, principal, guidance counselor, and other school personnel; ensuring that children are in appropriate educational placements; working individually in play and art therapy with the child; and doing group work in the classroom. Thus, while the specialist is focused on the needs of an individual child, she often becomes a resource to the entire classroom.

  In addition to her work in the schools, the psycho-education specialist maintains close contact with Family Network clinicians and treatment parents to ensure continuity between the home and school interventions. The specialist has been particularly successful in helping children with their initial adjustment to a new school upon entering a treatment home. The specialist can help to alleviate some of the stress by working through administrative and placement procedures and by working directly with the child throughout the orientation process. If, at a later point in time, the child moves to another foster home or an adoptive home, the specialist follows the child to the new school to enhance continuity. The services of the psycho-educational specialist have allowed many children to remain in community schools, in some cases with increased opportunities for mainstreaming. It is felt that without the resources, consultation, and support provided brought by the specialist, many children would be in more restrictive or segregated educational placements.

- Summer Program - A summer program is operated by the Family Network Program to provide both therapeutic and recreational activities for the youngsters and to relieve the extra stress that treatment parents often experience in the summer months. The summer program consists of scheduled activities one or two days per week for all children and program staff. The program includes special events at parks, skating rinks, and the like as well as trips to Disney World, Busch Gardens, and Seaquarium. Throughout the year the program provides occasional recreational activities. For example, staff are made available to supervise children at a nearby skating rink during inservice training sessions for treatment parents. Evening recreational programs may be planned during the Christmas season to allow parents to have time for shopping.

- Medical, Dental and Family Planning Services - Medical and dental services are arranged by treatment parents, but supported through other sources. Children who are HRS-dependent are covered by Medicaid; the parents or guardians of nondependent children are responsible for costs of medical and dental care. Birth control and sex education also are provided to children involved with the program. Both natural parents and treatment parents are told that youngsters will receive information and services in the area of sex and birth control. Girls attend a family planning clinic at the Health Department for instruction and birth control if they request it. Boys receive instruction in sex and birth control including the use of condoms.

  To date, there have been four pregnancies among girls in treatment homes. In these cases, counseling is provided regarding the options. If the girl chooses to keep the child, both she and the baby may remain in the treatment home, with the adolescent clearly responsible for caring for her own child. In one case, the adolescent chose to give up the baby for adoption after a short period of time. If the treatment parents are unable or unwilling to handle a pregnant youngster and a baby, the girl is moved to a different treatment home.

- Employment Assistance - Most of the youngsters in the program who are 14 years of age or older receive assistance in locating and maintaining some type of job. Staff often work with the Job Training Partnership Act program to obtain appropriate jobs for youth.

Services to natural families comprise another aspect of the intervention provided by the Family Network Program. A performance agreement with the natural parents is developed when the child enters the program. The performance agreement is intended to specify what services the natural parents agree to participate in, such as counseling or parenting classes. For HRS-dependent youngsters, the performance agreement is developed collaboratively by the parents, HRS caseworker, and Family Network clinician, and it specifies what changes the natural parents must achieve in order to have the child returned home on completion of the treatment program.

Family Network staff typically visit natural parents at their home on a monthly basis. The visits are used to discuss how visits between the natural parents and child are progressing as well as to explore the natural parents' concerns, feelings, and problems. The clinician often provides counseling to natural parents, but they also may be involved in outpatient counseling at the Lee Mental Health Center or elsewhere. Additionally, natural parents may be involved in parenting classes at the Center, either voluntarily or by court order. At one time the program attempted to organize a natural parents' group, but did not find enough commonalities among participants and ultimately abandoned this approach.

The program indicates that providing therapy and other services to natural parents is an important part of the intervention, particularly when reunification is the goal. However, this has proven to be a frustrating and difficult task. Program staff estimate that approximately 30 percent of the children have no family and are in permanent foster care or are preparing for adoption. A substantial portion of the natural parents (as many as 40 percent) are perceived as disinterested and have not responded to clinicians' attempts to engage them in the program. Many have serious and intense personal problems. The remaining 30 percent of natural parents are involved with the program in some way. Staff acknowledge that, despite the difficulties, services to natural families need strengthening and that creative methods are needed to engage and work productively with families.

In some cases, treatment parents work effectively with natural parents. Natural parents and treatment parents may see each other when children are picked up for visits, and may spend considerable amounts of time talking and sharing information and ideas. Regular phone contact also may occur between natural parents and treatment parents, and over time a "therapeutic" and supportive relationship may evolve. This supportive relationship may continue even after the child returns home, and treatment parents can serve as an ongoing resource to the natural family. Program staff note that open communication between treatment parents and natural parents effectively limits the manipulation that the child can create between them and increases mutual understanding and respect. Treatment parents, however, are free to determine whether they wish to or feel comfortable working with the natural parents in each case.

Discharge and Follow-Up Phase - Discharge and follow-up services represent the final phase of service delivery. The length of treatment in therapeutic foster care ranges from six months to one and one half years, with the average course of treatment being approximately one year. The IRT program has somewhat longer expected lengths of stay, averaging 18 months. Despite these averages, no rigid time limits are imposed by the program. The program feels that time limits would put undue pressure on the child and treatment family and that the length of stay should be based on the needs and progress of the child.

Discharge plans are formulated as soon as staff and treatment parents begin to know the child. While discharge plans may be revised if necessary, an attempt is made to establish the long-term placement goals early in the service delivery process. Ideally, the program seeks to discharge the child to a less restrictive environment at the end of treatment. In many cases (76 percent in 1988-89), this means a return to the natural family. If reunification is the plan, home visits are increased prior to discharge, and staff meet more frequently with natural parents to review visits and address problems.

If returning home is not possible, long-term foster care or adoption may be planned. In the case of long-term foster care, the child may remain in the treatment home, with the treatment parents dropping back to the regular foster care rate of reimbursement. In some cases, treatment parents do adopt the child. While long-term placement with treatment parents is not always a viable option, the program prefers this solution to moving the child to a new foster or adoptive home when possible. Long-term placement in therapeutic foster care is unusual for the program. In one case, however, the program has kept a child in a treatment home at therapeutic foster care rates for a period of three years.

Another potential discharge placement for older adolescents is a transitional living program operated by the Youth Shelter in Lee County. Youngsters live in their own apartments and are required to work or to be in school during the day. Program staff teach skills including daily living skills and job seeking and keeping skills.

Review of a 1986 sample with 21 children discharged revealed that 43 percent returned home, 19 percent were adopted, and 10 percent entered independent living. The remaining discharges were considered "unsuccessful" since the youngsters (29 percent) entered more restrictive placements such as wilderness camps and residential treatment facilities.

Regardless of the actual placement, the program offers aftercare services for as long as necessary following discharge. Aftercare services involve visits by Family Network clinicians which may occur as often as weekly during the first months following discharge. Visits may decrease over time according to the individual needs of each child and family. The program attempts to remain a resource to the child even after the follow-up period is completed. Children or parents can call if they need assistance or are in crisis, and children can come back into the program if necessary.

Networking and Linkages

The Family Network Program pays careful attention to its relationship with other child-serving agencies and systems in the community. Many linkages are forged on a person-to-person basis, with the Program Director and staff establishing friendships and developing trust with key actors in other agencies. These types of personal relationships set the stage for frequent interchanges as well as for handling disagreements that inevitably arise.

An important factor in the program's linkages is the attitude toward other agencies. Program leadership and staff emphasize the importance of maintaining a cooperative attitude and treating other agencies with respect and positive regard, minimizing criticism or blame. They maintain the stance that "we are all here to help the child" and the expectation that personnel from all agencies share this commitment. The program consciously attempts to support other agencies and to be responsive to their needs. Additionally, the program has an excellent reputation among other community agencies, and the Program Director and staff are held in high regard.

The program's relationship with HRS is considered one of the most critical to its operation. The linkage is defined by a written working agreement between HRS and the Family Network Program which was developed for the purpose of improving service provision and coordination. The agreement specifies the roles and responsibilities of each agency regarding children who are in HRS custody and are placed in the program, and it establishes a basis for a team approach between the agencies. (The agreement is included at the end of this section.) In order to ensure ongoing communication and coordination, weekly meetings are held involving the Family Network Program Director and the HRS Supervisor. Monthly staffings are held with all HRS staff in both the Adoption and Foster Care Units to review the home and school progress of children in the program, address problems, and develop action plans for individual children. Typically, Family Network clinicians and HRS caseworkers have weekly telephone contact regarding each individual child; phone contact may be more frequent when problems or crises arise. Other evidence of collaboration can be found in the occasional sharing of foster home resources. If, through its recruitment efforts, the Family Network Program identifies a home that may not be suitable for specialized therapeutic purposes but might be appropriate as a regular foster home, the home is referred to HRS.

Another vital linkage is with the school system. The program is fortunate in that it relates to only one school district. As a result, the program knows the school administrators, teachers, and special education resources and has developed a well-functioning network of relationships with them. Through these relationships, the program has greater ability to influence the educational placements for children and to work out school-related problems that occur. The psycho-educational specialist is an asset in the program's relationship with the schools since most of her time is spent in the schools serving as a resource to school personnel. The program reports that, unlike many therapeutic foster care programs, they do not encounter significant resistance from the schools in accepting and serving children placed in treatment homes. There may, however, be disagreements as to the most appropriate educational placement for individual children.

The program also attempts to work closely with the courts and juvenile justice agency. Much of their work with the courts is directed at ensuring that judges do not order children into the program inappropriately. Staff often attend delinquency and dependency proceedings and have considerable input regarding participation in the program.

In addition to these linkages between the Family Network Program and other key agencies, the program is involved in a number of multi-agency structures established in the area to enhance the coordination of services. As noted, the Program Director sits on the 10-member Case Review Committee (CRC) along with the Director of Children's Services at the Lee Mental Health Center, the Lee County Foster Care Supervisor, two district HRS representatives, two school representatives, a mental health center representative from another county, a private child psychiatrist, and a guardian "ad litum." This committee screens all children referred for therapeutic placements outside of the home and makes decisions for such placement, based upon a strong philosophical commitment to the concept of treatment in the least restrictive setting. The interagency and multidisciplinary committee also has monies available to fund services for children who are not HRS-dependent. Creative combinations of funds from the CRC and other sources have been used to support appropriate packages of services for youngsters. In some cases, the CRC has picked up the difference between the actual cost of services and the funding available from other sources.

The program participates in another multi-agency structure, the Lee County Network for Children and Youth which was started in 1986. The Network consists of all child-serving agencies as well as parents and citizens. The stated purposes of the Network include promoting the development of a continuum of care for children within the county, preventing duplication of effort, enhancing coordination of services, and advocating for children's services. Through its committee structure, the Network has been active in a number of areas, most notably in holding open forums for state legislators, establishing personal contacts with legislators to foster an interest in children's issues and services, and supporting a referendum to establish a local tax base for services to children. The Network holds meetings monthly and publishes a monthly newsletter. Among its plans are to assist in conducting a needs assessment regarding children's services and updating the needs assessment annually. Thus, the Network plays a system-level coordination role by identifying gaps in the system of care and advocating for needed services. The Network also provides a forum for mutual support among the many agencies involved in serving children and adolescents.

"SEDNET" (Seriously Emotionally Disturbed Network), funded jointly by the Florida education and mental health agencies, represents yet another multi-agency structure addressing the needs of troubled youngsters. SEDNET involves a five-county area including Lee County and is intended to ensure that children identified as severely emotionally disturbed are adequately served in the schools. Two staff persons and an oversight committee (on which the Family Network Program Director serves) play a coordinating, monitoring, and networking role to ensure appropriate service delivery.

Clients

The first clients served by the Family Network Program were all adolescents. Over time, the program began to accept younger children, and the age range of clients served currently is 4 to 17. While younger children are accepted, the majority of children served by the program are still adolescents. Data for the 1987-88 contract year reflect that 70 percent of the youngsters in the therapeutic foster care component were over age 12. The IRT program appears to focus even more heavily on adolescents, with 93 percent of the youngsters served during 1987-88 over age 12.

The program tends to serve somewhat more males (approximately 60 percent) than females (approximately 40 percent). The clients served by the program are approximately 80 to 90 percent white; with the remaining clients being black or Hispanic. Further, the clients served by the program tend to be from lower socio-economic levels, with approximately 76 percent of the children served considered Title XX eligible.

In order to be admitted to the program, every child must have a DSM III diagnosis and a diagnosis by a licensed psychologist or psychiatrist. Accordingly, psychological testing is part of the admission process if such an evaluation has not already been conducted. Although a diagnosis is required for admission, the program does not rely on the diagnosis per se in planning or implementing the treatment program. The vast majority of children in the program are described simply as "emotionally disturbed."

The youngsters entering the program are characterized by a wide range of presenting problems. These include histories of physical and sexual abuse, sleep disturbances, enuresis or encopresis, attention deficit disorders, aggressiveness and destructiveness, withdrawal, delinquency, truancy, school problems, substance abuse, poor interpersonal relationships, sexual acting out, and depression. There are some types of youngsters that the program generally will not accept. Those with IQs below 80 in combination with severe behavioral problems have not responded well to the treatment provided by the program. The program speculates that both treatment parents and staff lack the expertise needed to work successfully with this population, and may seek additional training in this area.

Youths who have severe substance abuse problems and who can be considered chemically dependent also are inappropriate for the program. The program accepts youths who have used drugs; most adolescents in the program have at least experimented with drugs. Program staff feel that youngsters who are chemically dependent fare better when they are removed from the source of drugs, which is difficult to accomplish with a therapeutic foster care approach. The program is careful in evaluating youngsters with active psychoses for potential participation. Usually, the IRT component is used to serve children who are actively psychotic. Youngsters with a history of fire setting are not excluded from the program, but the program is especially cautious in determining the placement and the treatment plan.

The majority of the children served by the program, approximately 80 percent, have been adjudicated dependent upon the state and are in the custody of HRS. However, children may participate in the program without a legal transfer of custody to the state. These children enter the program on the basis of a voluntary agreement signed by the natural parents or legal guardian. The agreement specifies what services will be provided by the Family Network Program as well as the ongoing responsibilities of the parents. The parents must agree to continue their legal and financial responsibility for the child, participate and cooperate with the program, pay for needed medical care, and, in some cases, contribute a specified monthly sum toward the cost of services. The Family Network Care Agreement is included at the end of this section.

Staffing

The Family Network Program is staffed by a Program Director, six clinicians, and one psycho-educational specialist. The staff is comprised of four males and four females, all of whom are white since there have been few minority applicants for open positions. For clinical staff positions, the minimum requirements include a bachelor's degree plus relevant work experience. Two staff members are at the master's degree level, and six are at the bachelor's level.

The staff selection process includes interviews with the Program Director and with the rest of the staff, and staff members have considerable input in evaluating and selecting new staff. Beyond educational and experience requirements, the program looks for a range of personal qualities including flexibility, a sense of humor, the ability to adapt to a nontraditional work schedule, and the ability to work with a wide range of different types of people. Strong clinical skills and special areas of expertise, e.g., in working with sexually abused children, are desirable. Further, the program looks for new staff people who will complement and work well with the rest of the staff.

The staffing pattern used by the program involves using one staff person to be the focal point of services for each child. The same staff person, referred to as the "clinician," serves as both therapist and case manager for the child as well as working with the treatment parents, natural parents, HRS caseworker, schools, and other agencies. The same clinician is on-call 24 hours a day for his or her clients, although other staff are familiar with the cases and provide back-up. Thus, the clinician is responsible for providing, coordinating, and overseeing all services for the child.

This "clinical/case manager concept" recognizes the importance of continuity of services with all involved parties. The program contends that separating therapeutic and case management functions is less effective than having a single staff person function as a generalist and handle all aspects of the intervention. Further, the program contends that it is most effective to have a single staff person working with all parties -- the child, treatment parents, natural parents, and involved agencies. While HRS caseworkers generally have official case manager status for most children in the program, it is the Family Network clinicians who fulfill case management functions. In order to ensure that clinicians can provide these extensive services, caseloads are limited to about six therapeutic foster care cases and one IRT case.

The one exception to the staff of generalists involves the use of a psycho-educational specialist to work with the schools. The rationale for using a psycho-educational specialist is that working with the school requires special skills and knowledge and that clinicians, who may be overwhelmed with their other responsibilities, may not have adequate time to work extensively in the schools. Since children bring their problems to school, and teachers spend nearly as much time with children as treatment parents, the school environment warrants considerable attention. The role of the psycho-educational specialist includes a variety of activities and interactions with schools administrators, guidance counselors, and teachers, including:

o Ensuring children are in appropriate educational placements;
o Developing a treatment plan to meet the child's needs in school, including behavioral programs when needed;
o Working with teachers as a consultant, resource, support system, and liaison with the program;
o Conducting group work in the classrooms such as using puppets or role plays;
o Working with individual children using play therapy and art and music therapy; and
o Participating on the treatment team, attending staffings, and coordinating services with clinicians.

It should be noted that the Lee Mental Health Center developed an entire program modeled after this outreach approach, the Children's Learning Alternative Support System or "CLASS" program.

Staff attend the monthly inservice training sessions held for treatment parents as well as inservice training events held for the entire Mental Health Center staff. Additionally, funds are provided to support attending at least one conference per year outside of the area. Staff performance is evaluated annually.

The program reports that it has remarkably low rates of staff turnover. Over its 13 years of operation, only three staff members left the program -- two due to relocation and one due to burnout. The addition of new staff primarily reflects expansion of the program rather than replacement of staff. The ability of the program to retain staff is attributed to a variety of factors. First, salaries paid by the Center are competitive with other local social services agencies. Additionally, the mutual support and camaraderie that has developed among staff members is a major factor in preventing feelings of frustration and burnout. Staff share with each other, cover for each other, and socialize together. This helps staff to deal with the inevitable stresses involved in providing therapeutic foster care services.

Treatment Parents

The treatment parents are considered the most critical members of the treatment team and the primary treatment agents. The Family Network Program originally limited treatment parenting to couples, but over the years has expanded the pool of eligible candidates to include single parents. Of the current pool of 36 treatment homes, 5 are single parents. A small percentage of treatment parents who become involved with the program were already licensed as regular foster parents; the majority are newly recruited to provide therapeutic foster care services. For the therapeutic foster care component, both treatment parents may work outside the home. In the IRT component, however, treatment parenting is presented as a full-time job opportunity, and one parent must be at home on a full-time basis.

The age of treatment parents ranges from 25 to 65, and nearly half (47 percent) have natural children in the home. The program indicates that natural children can serve as role models for foster children if they are healthy and secure. In some cases, natural children may show some resentment at the addition of foster children to the family. Reportedly, this problem is minimized when there are significant age differences, particularly when natural children are the oldest in the household.

In its ongoing search for qualified treatment parents, the program targets people who are already very busy and committed in their lives. People who like children, appear altruistic, and have the inner strength to cope in times of trouble are seen as good candidates. Recruitment activities are specifically directed at reaching these types of individuals.

Recruitment is handled, to a great extent, by the Program Director. He sees recruitment as a selling job, and he focuses his efforts heavily on churches, synagogues, school systems, and service clubs. The program is careful to approach only mainstream churches, avoiding esoteric or fanatic sects where members would be unlikely to have the flexibility and tolerance for treatment parenting. One strategy which has been particularly successful involves talking with priests, ministers, and rabbis about the program and asking them to identify one family within their congregation that might be qualified and interested in being treatment parents. Periodically, letters are sent to all school employees with the permission of the school superintendent.

Classified ads and exposure through other media have been used in the past, but have proven less productive for the program. The majority of responses to advertisements are from applicants who ultimately are deemed inappropriate. Program staff have had greater success by targeting places where they are more likely to reach the types of people they are looking for. Classified advertisements are used periodically for the IRT program, since treatment parenting is offered as an alternative for persons who may be seeking full-time employment. Treatment parents themselves have been successful in recruiting new homes as well.

The program has had considerable success in recruiting new treatment homes. Over the past several years, 29 new homes were recruited and licensed. Much of the success in recruitment is attributed to the efforts of the Program Director. He has a great deal of personal experience in working with troubled youngsters as he had adopted six emotionally disturbed children. He has found that sharing his own experiences with others is often an effective marketing tool. A weakness in recruitment relates to minority treatment homes. Currently, only 2 of 36 treatment homes are black, and the program is now reaching out to churches and other organizations in the black community in an attempt to recruit more minority treatment parents.

The selection process generally involves visiting the home and conducting a series of interviews. The initial screening interview with the Program Director is used to begin to assess whether the family is appropriate for therapeutic foster care. The interview investigates a wide range of areas including family strengths and weaknesses, personal strengths and weaknesses, motivational factors, experience with youths, support systems available, and the nature of the house, neighborhood, and schools. Additionally, the initial interview is used to begin to educate the potential treatment parents about the Family Network Program, therapeutic foster care clients and their behavior, and licensing procedures. Subsequent interviews continue the process of exploring the candidates' qualifications and appropriateness as well as the program's philosophy, goals, treatment approach, and expectations of treatment parents.

As soon as it appears that a couple may be interested and appropriate for treatment parenting, they are encouraged to begin the preservice training classes provided by HRS and to attend the monthly inservice training sessions offered by the Family Network Program. The additional information learned in these sessions can feed into the final decision about participating in therapeutic foster care.

The licensing of treatment homes is handled by the State agency, HRS, and not by the Lee Mental Health Center. For new homes, the licensing process can take from three to as much as six months' time. Personal references and a check of criminal and child abuse records are required for licensure as well as fire and sanitation inspections. Additionally, completion of preservice training is required. The MAPP (Model Approach to Partnerships and Parenting published by the Child Welfare Institute, Center for Foster Care and Residential Care in Atlanta) preservice training program is used, which consists of weekly sessions for a period of ten weeks. This is the same preservice training required of regular foster parents.

As early as possible, treatment parent candidates become involved in the inservice training sessions offered by the Family Network Program. These monthly sessions provide a combination of training and support for treatment parents. A portion of the evening session is devoted to technical training on a particular topic, and another segment is devoted to sharing information and strategies for working with individual youngsters. During inservice sessions, staff supervision is provided to supervise children (including natural children) at a nearby roller skating rink. Some of the topics covered during inservice training sessions have included:

- Sexually transmitted diseases,
- Understanding adolescents,
- Teenage sexuality,
- Frustrations in dealing with emotionally disturbed youth and realistic expectations,
- Lying: understanding and dealing with it,
- Stealing: understanding and dealing with it,
- Anger: understanding and dealing with it, and
- Treatment philosophy of therapeutic foster care.

For new homes, much of the training is provided by staff with an "on-the-job" training approach. Program leadership and staff prefer relying more heavily on on-the-job training coupled with inservice training rather than on extensive preservice training. This approach is based on the belief that it difficult to intellectually understand the process of treatment parenting and that treatment parents learn better when they experience it and learn as they go with extensive technical assistance and support. Thus, preservice training is limited to the ten-week series required of all foster parents, and most of the specialized training for therapeutic foster care is provided through inservice training sessions and on-the-job training and supervision.

Both individualized and groups training is devoted to ensuring that treatment parents are intimately familiar with key program policies. For example, the discipline policy encourages the use of positive methods of disciple and prohibits physical discipline or such practices as placing a child in a locked room. The religious practice policy prohibits treatment parents from proselytizing or putting pressure on foster children to attend the treatment parents' church. Treatment parents may invite children to attend and, with the agreement of the child and natural parents, the children may accompany treatment parents to church. If desired by the child, treatment parents are required to provide transportation to religious services in the denomination of the child's choice.

The rate of attrition of treatment homes is relatively low, 14 percent in 1987-88 and only 3 percent in 1988-89. Many treatment parents stay with the program for long periods of time. In fact, some three of the six original treatment families recruited at the program's inception in 1976 are still with the program today. Loss of treatment parents is attributed more to moving away from the area than to burnout. In a small percentage of cases, perhaps 10 percent, treatment parents are lost to the program by virtue of adopting the child in placement. Despite the difficulties and frustrations, treatment parents report a great deal of personal satisfaction in fulfilling this role.

Treatment parents in the therapeutic foster care component receive the intensive foster care board rate from HRS plus a monthly payment from the Lee Mental Health Center. The board rate is $321 for children under age 12 and $394 for children over 12, and the monthly supplement from the Center is $150. Thus, the total amount received by treatment parents is $471 per month for younger children and $544 per month for adolescents. The program describes this as essentially a break-even proposition for parents. The IRT program offers considerably more compensation for treatment parents and is regarded more as a professional job. The total per diem payment to parents is $49.31, or approximately $1500 per month or $18,000 per year.

Resources

The costs of the Family Network Program are estimated at $25 - $30 per day for the therapeutic foster care component and $64 per day for the IRT component. At this cost, the program compares favorably with other residential treatment options in Florida and is considered to be a cost-efficient approach.

The annual budget for the Family Network Program (therapeutic foster care and IRT combined) is approximately $490,000. Two different funding mechanisms are used for the two components. The therapeutic foster care component is funded through a fixed price contract with HRS. The contact specifies that the program will provide a certain number of therapeutic foster care beds and includes several performance outcome measures against which the program's performance is monitored. The standards specify that:

- o The provider will maintain an 80 percent utilization of the negotiated contract bed number.
- o Individual treatment plans will be developed within 14 days of admission, should include specific measurements, and should be shared with the family and child.

o Sixty percent of the children served will be discharged to a less restrictive program.

o Seventy-five percent of the children served will successfully complete the program within 18 months.

o Sixty percent of those children discharged to a less restrictive setting will be maintained in that setting for six months following discharge.

o The program will recruit and train at least six new homes during the contract year.

The 1986-87 contract required 36 therapeutic foster home beds and was funded at a level of $210,000 from the HRS, with an additional $22,000 in local match provided by the Lee County Commission. The IRT component is not funded on the basis of a fixed price contract but rather through a per diem reimbursement mechanism. HRS provides the program with $63.59 per day per client for individual residential treatment services up to a maximum of $180,000.

The principal sources of funding for the program, therefore, are the State and the Lee County Commission through its local match. There are some additional sources of revenue for the program in fee collections and third party reimbursements. In some cases, fees are collected from parents, and private insurers may provide reimbursement for some of the services involved in therapeutic foster care such as psychiatric services or individual therapy. Fees and third party reimbursements are rebated to HRS. For children who are not HRS-dependent, funding must be secured to cover the board portion of the cost of services. These costs might be covered by purchase-of-service funds from the Case Review Committee, from the child's family, or from other private payment sources.

Most of the children in the program are Medicaid-eligible, and Medicaid is billed for services such as psychiatric services and individual therapy. Additionally, Florida Medicaid regulations allow reimbursement for admission services, admission staffings, group therapy, and collateral therapy including working with natural parents, treatment parents, HRS caseworkers, and school personnel directly related to the treatment of the child. Receipts from Medicaid are rebated to the State.

Evaluation

To date, the program has conducted little formal evaluation. This is attributed to lack of time and resources for sophisticated evaluations as well as to some resistance among staff and program management to excessive data collection. However, there has been some attempt to document the program's effectiveness through the HRS monitoring process and through Center-wide evaluation activities.

The HRS monitoring process involves obtaining detailed feedback from referral agencies, site visits, and reviews of clinical and financial records as well as meetings with treatment parents, natural parents, children, schools, and other agencies. Another aspect of this process involves measuring the program's performance against the outcome measures specified in the contract for services with HRS, such as utilization rate, timely development of treatment plans, and rate of successful discharges. Two of the most critical outcome measures included in the contract specify that:

o Sixty percent of the children served will be discharged to a less restrictive program, and

o Sixty percent of the those children discharged to a less restrictive setting will be maintained in that setting for six months following discharge.

The program also considers "successful discharge" to be its major outcome measure. A successful discharge is defined as one in which the child moves to a less restrictive setting (e.g., home, foster home, adoptive home, or independent living). Data for two separate time periods show that the program far exceeds the contract requirement that 60 percent of the youngsters be discharged to less restrictive settings.

During the 1985-86 contract year, 21 children were discharged from the therapeutic foster care program. Seventy-one percent of the discharges were considered successful since the youngsters returned home (43 percent), were adopted (19 percent), or went to independent living (10 percent). Twenty-nine percent of the discharges were unsuccessful, with youngsters entering more restrictive settings such as wilderness camp, a juvenile justice facility, and a residential treatment center.

During the 1987-88 contract year, the results for the 22 youngsters discharged from the therapeutic foster care component were even more noteworthy. Twenty of these youngsters (91 percent) were discharged to less restrictive environments, with 14 (70 percent) returning home and 6 (30 percent) adopted. Only two youngsters (9 percent) went to more restrictive settings. In the six months following discharge, none of the youths in the successful discharge category returned to more restrictive settings.

The results of the IRT component for the 1987-88 contract year substantiate the program's success in working with the most seriously disturbed youngsters. During this year, eight youngsters were discharged, 75 percent of whom went to less restrictive settings. Only two youngsters (25 percent) were admitted to more restrictive settings, a state hospital and a delinquency commitment program. Again, in the six months post-discharge, none of the youths in the successful discharge category reverted to more restrictive placements.

Center-wide evaluation activities include monitoring the number of clients served and the units of service provided as well as periodic utilization reviews of individual cases. A client satisfaction survey is a part of the overall Center's program evaluation efforts and involves a questionnaire given to all children over age 10 and to natural parents. While the response rate for the client satisfaction survey for Family Network Program participants has been low, respondents generally are satisfied with the program, feel that staff seem very interested in helping, and feel that at least some progress has been made as a result of participation.

Major Strengths and Problems

Program administrators, staff, providers from other agencies, treatment parents, and natural parents cited the factors they feel make the Family Network Program effective. The major strengths identified include the following:

- Commitment to serving children in the community.
- Flexibility to design treatment programs specific to each child's needs.
- Concerned, caring, dedicated staff.
- Dedicated, knowledgeable, and charismatic program director.
- Small caseloads which allow staff to devote a great deal of time to each child and treatment family.
- Twenty-four hour availability and willingness of staff to assist with problems or crises at any time.

- Dedicated, conscientious, and loving treatment parents whose commitment to the children often extends beyond the actual period of services.

Many informants noted that the quality of the treatment parents is a key factor in the program's success as well as the quality of the staff and program leadership. All are perceived as dedicated, committed, caring, and competent individuals and are highly respected.

Another strength of the program is in its willingness to accept more severely disturbed youngsters than many other programs. It was noted that the program takes risks by accepting youngsters who have been rejected by other residential programs or who have extensive histories of institutionalization in state hospitals. This willingness to take chances is considered by many to be an important strength.

Several problem areas were noted as well. A number of treatment parents indicated that the preservice training provided by HRS for all foster parents does not offer sufficient preparation for the challenges of working with disturbed children. While they are satisfied with the inservice training and individualized consultation provided by staff, they feel that additional training prior to providing services to a child would be helpful. This additional preservice training, beyond the HRS program, would focus specifically on the skills needed to work with severely emotionally disturbed children.

A second problem area relates to the level of compensation provided in the therapeutic foster care component of the program. The HRS maintenance payment plus the $150 supplement from the program are not always enough to provide for all the needs of the child, particularly in the context of a middle class lifestyle. As a result, many treatment parents assume the additional costs themselves for such items as clothing, toys, and occasional visits to restaurants. The concern is that the children in treatment homes may become an economic burden to treatment parents.

Another problem noted by treatment parents involves the inability to obtain property damage and liability insurance coverage. According to treatment parents, many homeowners insurance policies do not cover vandalism or damage to the home when a member of the household is responsible for the damage. In addition, they do not feel adequately protected from suits filed by natural parents, for example, or neighbors. Such insurance generally is unavailable to treatment parents or the cost is prohibitive.

Like most therapeutic foster care programs, the Family Network Program faces the occasional problems of abuse allegations against treatment parents. There have been about four or five investigations of alleged physical abuse, none of which was founded. When such allegations occur, the child may be placed temporarily in a back-up treatment home while an investigation is conducted. If the allegation is unfounded, the child generally is returned to the treatment home.

Other problems identified include:

- Difficulty recruiting minority treatment parents.

- Difficulty in engaging natural parents in services and the need to strengthen the services provided to natural parents.

- Resistance of schools to serving severely emotionally disturbed youngsters and the difficulty in obtaining appropriate special education services.

- o Difficulty for treatment parents to return children to home situations that have not improved appreciably.

- o Massive paper work demands generated by multiple funding sources.

Dissemination

The Family Network Program is heavily involved in activities to promote the development of therapeutic foster care programs and to provide assistance to developing programs. The Family Network Program was the first therapeutic foster care program in the State of Florida. Currently, there are more than 20 such programs in Florida, many of which are modeled after the Family Network Program's approach. The Program Director and staff have provided extensive start-up consultation to at least 10 of these programs. Further, other programs in Florida are beginning to add an IRT component based upon the success of this component at the Lee Mental Health Center.

In addition, the program has organized annual conferences on therapeutic foster care. These two-day conferences offer two tracks -- one for existing programs and one for people who want to start new programs. Persons from existing programs are provided with the opportunity to share ideas, network, and provide mutual support. Those interested in starting new programs receive information and consultation and have the opportunity to visit the Family Network Program. The first conference was held in 1986; three such conferences have been held to date.

A more formalized mechanism for networking Florida's therapeutic foster care programs has recently been organized. The Program Director of the Family Network Program was instrumental in forming the Therapeutic Foster Home Network of Florida in 1988 and currently serves as President. The Network holds quarterly meetings and will sponsor annual statewide conferences on therapeutic foster care. One focus of the Network involves an attempt to improve data collection and evaluation among programs, with particular attention to collecting comparable information across programs in the state. The Network is requesting resources from the state to assist in improving the data collection and evaluation activities of all the therapeutic foster care programs in the state.

Case Examples

A 12-year-old male ("C") from a well-to-do family, was referred to the IRT program. C had a history of several prior psychiatric hospitalizations and at the time of referral was rejected by a number of residential treatment programs in the state. C's diagnosis was childhood schizophrenia, and his symptoms included auditory and visual hallucinations, aggressiveness, and agitation. C was maintained on medication, but still experienced hallucinations. He was placed in an IRT home and in a special education class at a middle school for two hours a day. C stabilized in his school placement, although his verbalizations about sex and other symptoms have led school personnel to consider placing him in a separate school for disturbed youngsters. C stabilized in his IRT home and remained there for a period of 12 months. Progress within the treatment home was gradual, but consistently positive. The treatment parents provided an extremely supportive and caring environment and, in the context of their accepting relationship, worked with C on confronting reality issues. The treatment parents also maintained an open and communicative relationship with C's mother throughout the placement period. C was returned to his mother several months earlier than originally planned due to an impending move to another state. C remained with his mother following the move and was placed in a day treatment program in his new community.

A five-year-old girl ("T") was referred to the Family Network Program by HRS along with her six-year-old sister. At the time of referral, T was in a regular foster home and having considerable difficulty. T and her three siblings were removed from their home for reasons of neglect after a period of protective supervision. T was developmentally delayed and manifested problems including nightmares, pulling her hair out, and other symptoms of severe anxiety. It was further discovered that T was a victim of sexual abuse by her father. T was placed in a therapeutic foster home first, and was later joined in the same home by her sister. The long-range plan involved reunification of both girls with their mother, who was seeking a divorce from the father and receiving therapy from the mental health center. T stabilized in the treatment home and made considerable progress. The Family Network clinician assigned to T had special expertise in the area of sexual abuse and paid particular attention to this issue. Individual and joint therapy was provided to T and her sister as well as self-esteem building activities and special attention was given to issues pertaining to victimization. T had frequent contact with her mother, and staff worked with T's natural mother as well as with her treatment parents. Despite attempts to work with T's natural mother, she never completed her performance agreement and ultimately freed T and her sister for adoption. T and her sister were adopted by the treatment parents.

Technical Assistance Resources

- Contract Between State of Florida Department of Health and Rehabilitative Services and Lee Mental Health Center, Inc. - Therapeutic Foster Homes

- Rate Agreement Between State of Florida Department of Health and Rehabilitative Services and Lee Mental Health Center, Inc. - Residential Treatment Services for Emotionally Disturbed Children and Youth

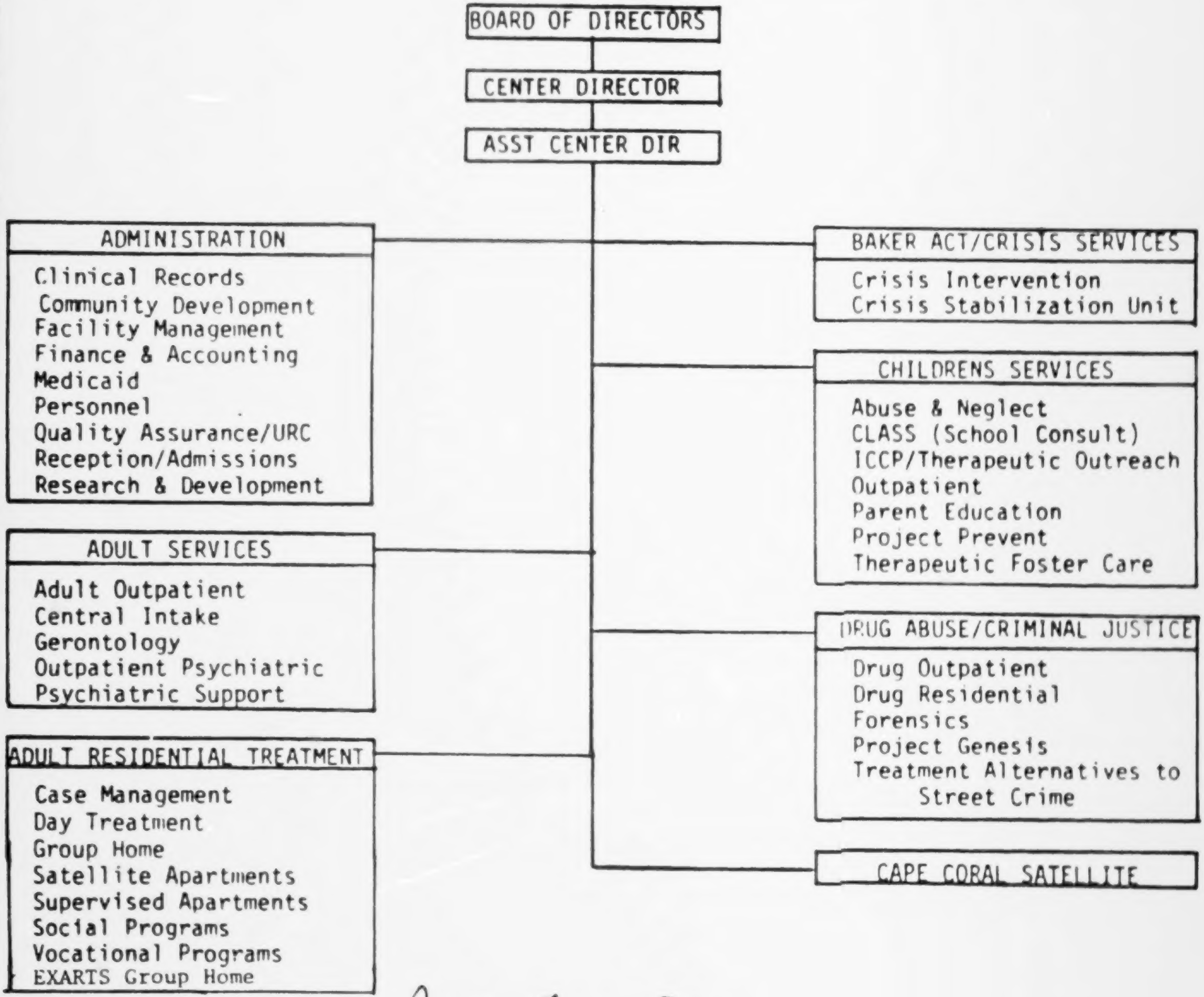
- Application for Funding of Emotionally Disturbed Children for Residential Treatment (Application to the Case Review Committee)

- Family Network Care Agreement (Voluntary placement agreement between natural parents and program)

- Program Forms:

  Treatment Consent Form for Minor Child
  Authorization for Release of Information
  Medicaid Audit
  Intake Evaluation - Client Information, Presenting Problems, and Service Planning
  Assessment - Treatment/Service Plan
  Evaluation of Client Functioning and Needs
  Individual Service Plan
  Discharge Planning Form
  Medicaid Certification and Tentative Treatment Plan
  Quarterly Report
  Discharge Summary

LEE MENTAL HEALTH CENTER
ORGANIZATIONAL CHART



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CENTER DIRECTOR

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- Research & Development

ADULT SERVICES

- Adult Outpatient
- Central Intake
- Gerontology
- Outpatient Psychiatric
- Psychiatric Support

ADULT RESIDENTIAL TREATMENT

- Case Management
- Day Treatment
- Group Home
- Satellite Apartments
- Supervised Apartments
- Social Programs
- Vocational Programs
- EXARTS Group Home

BAKER ACT/CRISIS SERVICES

- Crisis Intervention
- Crisis Stabilization Unit

CHILDRENS SERVICES

- Abuse & Neglect
- CLASS (School Consult)
- ICCP/Therapeutic Outreach
- Outpatient
- Parent Education
- Project Prevent
- Therapeutic Foster Care

DRUG ABUSE/CRIMINAL JUSTICE

- Drug Outpatient
- Drug Residential
- Forensics
- Project Genesis
- Treatment Alternatives to Street Crime

CAPE CORAL SATELLITE

Approved effective
July 1, 1988

Lewis Cooper, PhD
Center Director

CASE MANAGEMENT RESPONSIBILITIES FOR ADJUDICATED DEPENDENT CHILDREN PLACED IN THE THERAPEUTIC FOSTER HOME PROGRAM

1. Meet jointly with the family prior to placement of the child to discuss program, roles of each agency, need for Performance Agreement, Judicial Review, fee collection, etc.
2. Meet jointly with the biological parent(s) and child (if appropriate) to complete the Performance Agreement.

HRS	MHC
3. File Performance Agreement within thirty days with the court.	3. Place child in licensed home.
4. Complete all required HRS forms.	4. Primary case planning responsibility for child while in Therapeutic Foster Home Program.
5. May work with biological parents and maintain monthly contact with child when agreed upon jointly with the Mental Health Counselor.	5. Work with and maintain regular contact with child, foster parents, and biological parents.
6. Coordinate EPSDT Screening; arrange for medical appointments as necessary.	6. Notify HRS of needed medical appointments and request authorization for medical services.
7. Hold monthly staffings with MHC to discuss all joint cases; record all contacts including monthly reports from MHC. Incorporate monthly and quarterly reports from MHC into quarterly summaries.	7. Participate in monthly staffings with HRS to provide monthly reports on progress of Performance Agreement, treatment plans etc. to the Foster Care Counselor. Provide written quarterly reports to the Screening Committee and to HRS.
8. Prior to the Judicial Review; meet jointly with MHC, biological parents, foster parents, and child to evaluate progress form subsequent case plans as needed.(Continue current program, return child to biological family, placement in F.C.)	8. Participate in joint meeting to evaluate progress on Performance Agreement and primary responsibility in forming subsequent case plan as needed.

LEE MENTAL HEALTH CENTER, INC.

RUTH COOPER, Ph.D.
DIRECTOR

ADULT SERVICES
OUTPATIENT
EMERGENCY WALK IN
DAY TREATMENT (WINTU)
FORENSIC
GERONTOLOGY
PSYCHIATRIC
TREATMENT ALTERNATIVES TO STREET CRIME

CHILDREN'S SERVICES
OUTPATIENT
DAY TREATMENT
CHILD ABUSE AND NEGLECT
GENESIS/DRUG ABUSE PREVENTION
INTENSIVE CRISIS COUNSELING
PARENT EDUCATION
PROJECT PREVENT
THERAPEUTIC FOSTER HOMES

DRUG ABUSE SERVICES
OUTPATIENT
RESIDENTIAL

RESIDENTIAL
CRISIS STABILIZATION

SPECIAL SERVICES
PSYCHOLOGICAL EVALUATION
CASE MANAGEMENT
CONSULTATION AND EDUCATION
SATELLITE CLINICS

CAPE CORAL SATELLITE
574-LMHC

FAMILY NETWORK CARE AGREEMENT

Having Physical or legal custody of ____________________________
and believing the best interests of the child will be served, we,
____________________________________, enter into this agreement with
Lee Mental Health Family Network Project.

The Family Network Project's part in this care agreement is as follows:

1. We will temporarily provide quality care for the child for the period that the child is in placement. This includes: placement in a home where the parents are specifically trained to handle the problems of an emotionally disturbed child; weekly individual counseling; 24 hour crisis intervention, placement, and support in appropriate school and/or job program; and necessary medical treatment (reimbursed by the legal guardian).

2. Monthly conferences will be held with the parents/legal guardians to discuss progress and assess the needs of the child.

3. The average length of treatment is somewhere between 6 to 18 months. In the event that the child does not respond to treatmnet and we are unable to stablize the child in our program, we maintain the right to ask the parent/legal guardian to return the child back home to your care with a two week written notice. It is your responsibility to seek any additional placements although we can assist you.

We, ____, agree that our part in this program is as follows:

1. We will continue to assume legal and financial responsibility for the child.

2. We will make ourselves available for conferences at least monthly.

3. We will cooperate fully with the visit plan worked out and be willing to provide transportation when necessary.

4. We confer on the Family Network Project the right to act on our behalf for arranging medical care as deemed necessary. We understand that we continue to be financially responsible for such medical care.

5. We confer on the Family Network Project the right to act as "Parent" relative to the child's growth and development without interferance on our part.

continued.....

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6. We will place the child with an appropriate wardrobe. After placement, the foster parents will be responsible for the clothes and incidentals needed.

7. We will be able to contribute ______________________ monthly for the care of our child.

8. While our child is in treatment and working to change, we agree to whatever is necessary to change the home environment as outlined below:

1. ____
2. ____
3. ____
4. ____

____

Family Network Representative

____

Parent/Guardian

____

Witness

____

Parent/Guardian

____

Date

PRYDE (PRESSLEY RIDGE YOUTH DEVELOPMENT EXTENSION)
THE PRESSLEY RIDGE SCHOOLS
PITTSBURGH, PENNSYLVANIA

History

The Pressley Ridge Schools, a private, nonprofit child care corporation, was officially established in 1965 as a result of the merger of Pittsburgh's two oldest child care agencies. Both of these original agencies, the Protestant Orphan Asylum and the Pittsburgh and Allegheny Home for the Friendless, date back to the mid-1800s. Following the merger, the focus of the agency shifted from providing residential care for dependent children to working with troubled children. The combined residential treatment and school program offered by the agency was guided by the "reeducation" (or Re-ed) model, a nonpathology-oriented model which views treatment essentially as education.

Despite the high quality of the cottage-style residential treatment program, serious questions were raised about its continuation in the late 1970s. The costs of providing residential treatment were increasing, and the buildings required major renovation. Further, the effectiveness of the program was questioned, particularly in terms of the wisdom of grouping together, on a single campus, 50 or more boys and girls with serious emotional problems who might model and teach each other maladaptive behavior. These concerns eventually led to the closing of the residential treatment program in 1980.

The Executive Director of The Pressley Ridge Schools had been, for some time, searching for and considering more individualized alternatives to residential treatment. At a conference, he had once heard the somewhat outrageous suggestion that each staff person at a juvenile corrections institution take one child home and be responsible for that one child. The notion of taking a child home stuck with him. While he was not aware of existing therapeutic foster care programs at the time, he developed a vision for a new model of service delivery which would use a new group of professionals to provide treatment and serve as parents to troubled youngsters in home settings.

The Executive Director enlisted the help of a consultant, a West Virginia University professor on sabbatical, to explore the feasibility of this approach. The consultant researched the therapeutic foster care model and visited several existing programs as well as group homes based upon the Teaching Family model. Through this exploratory process, the philosophy and design of PRYDE began to take shape.

Two start-up grants ($145,000 from the Pennsylvania Council on Crime and Delinquency and $25,000 from the Pittsburgh Foundation) enabled actual program development to begin. The PRYDE Director was hired in 1981, and the first PRYDE parents were trained and youngsters placed during that year.

Since its inception, the program has expanded to two other states. The state of West Virginia requested proposals for therapeutic foster care, and PRYDE successfully submitted a proposal. As a result, PRYDE West Virginia was initiated in 1985 with the assistance of a $60,000 start-up grant from the state juvenile justice agency. The program currently operates from two offices serving the entire state.

In 1987, an intensified version of PRYDE was initiated in West Virginia to serve children with extremely severe behavioral problems requiring close supervision and highly individualized attention. This program was designed to treat children who were in out-of-state institutions, those at risk for placements in out-of-state treatment facilities, or those with histories of repeated failures in other treatment facilities.

The intensive PRYDE program offers a higher per diem payment to PRYDE parents as well as more on-site support from PRYDE staff, an array of specialists, and home modifications that may be necessary to keep the client and community safe (e.g., security systems). At the early stages of a placement, PRYDE parents and various assistants provide 24-hour direct observation and supervision of the child; such monitoring may be decreased as the youngster progresses. Continuous, individualized treatment is implemented by the PRYDE parents, assistants, and other members of the treatment team in accordance with the needs of the child.

Most recently, PRYDE responded to requests for proposals and, in 1988, established a program serving several Maryland counties including Baltimore. Currently, the program has the capacity to serve approximately 100 youngsters in Pennsylvania (65 in Pittsburgh and 35 in suburban Sewickley) 50 in West Virginia, and 50 in Maryland.

Community and Agency Context

The PRYDE program, located in three states, serves urban, suburban, and rural areas with vastly different characteristics. In Pennsylvania, PRYDE primarily serves Allegheny County, a large urban county which includes Pittsburgh and has a population of approximately 1.5 million. Pittsburgh is a city comprised of old, well-established neighborhoods with strong ethnic bonds. The ethnic communities include a number of Eastern European groups (Ukrainians, Poles, Czechs, etc.). The inner city has a large population of minorities, primarily black. The economy of the area has shifted in recent years due the shutdown of the steel industry, resulting in massive unemployment and retraining efforts. The high unemployment rate in the area during the early 1980s actually has had a favorable impact on the program's efforts to recruit treatment parents.

In addition to serving Allegheny County, PRYDE has small contracts with seven surrounding counties to serve approximately two or three youngsters per county. PRYDE's two Pennsylvania offices are located in Pittsburgh and in the nearby suburb of Sewickley, a rather exclusive area with a large population of young professionals.

In West Virginia, PRYDE serves extremely rural, isolated areas. The state is comprised of 55 rural counties with only one urban population center, Charleston. The entire state of West Virginia has a population size comparable to that of Allegheny County. The area is characterized by poverty, high unemployment due to the closing of mines and several heavy industries, and few job opportunities. Additionally, few community support services (whether special education, mental health, or others) are available throughout the state. Staff recruitment also is difficult since many individuals tend to leave West Virginia to seek greater opportunities elsewhere. Some variations in the model are necessitated to accommodate the challenges posed by the environment as well as the differences in the population of youngsters and treatment parents. A great deal of travel and long-distance telephone calls are required for staff to provide high levels of support to treatment parents who are spread out; staff typically operate out of the trunks of their cars. Extensive travel may also be required for treatment parents to meet as a group and for youngsters to visit their natural families. Due to the poor roads in rural areas, staff often must have four-wheel drive vehicles in order to reach homes. West Virginia offices are located in Clarksburg in northern West Virginia and in Beckley in the southern part of the state. In Maryland, PRYDE serves the highly urban area of Baltimore, with all the classic inner city problems, as well as several surrounding counties. It also serves the suburban community of Columbia where the PRYDE Maryland office is located.

While the population in West Virginia and the more suburban Pennsylvania areas is largely white, there is a significant minority population in Pittsburgh (approximately 20 percent) and in Baltimore (approximately 40 percent). Thus, 55 to 65 percent of the youngsters served by Pittsburgh PRYDE are black and more than half of the treatment parents in Pittsburgh are black.

As noted, The Pressley Ridge Schools was established in 1965 with the merger of two child care agencies which were originally founded more than 150 years ago. The agency is designed to provide treatment and education to troubled and troubling youngsters, and currently serves approximately 400 children in three states. In 1988-89, The Pressley Ridge Schools had an overall budget of $9 million and a staff of 215, including an array of professionals in the fields of mental health, counseling, special education, psychology, and psychiatry. In addition to PRYDE, the agency offers the following programs:

o Pressley Ridge Day School/Partial Hospitalization Program - Located in Pittsburgh, this program provides treatment and education in a classroom setting to 120 severely emotionally disturbed youngsters. Special education teachers, mental health specialists, and family liaison specialists form the primary treatment team and are supported by supervisors, psychologists, and psychiatrists.

o Pressley Ridge School at Laurel Park - This year-round residential treatment program is located in West Virginia and is designed to provide treatment, education, recreation, and prevocational services to troubled youth ages 10 to 17. The program has the capacity to serve 10 boys and 10 girls, most of whom are status offenders, and it operates according to the Re-ed model.

o Pressley Ridge School at Ohiopyle - This program provides a year-round residential treatment facility in a wilderness environment. The wilderness school operates on a variation of the Re-ed philosophy and provides a treatment and experiential educational program for 50 boys.

o Pressley Ridge Home Places/Alternative Living for the Dually Diagnosed - One of Pressley Ridge's newest programs, Home Places, is a spin-off of PRYDE, resulting from a successful pilot effort. Within the context of normal families, the program provides intensive treatment for children who are both mentally retarded and socially and emotionally troubled.

o Pressley Ridge Emergency Shelter Service (PRESS) - The PRESS program was started in 1986 and has the capacity to serve 20 adolescents daily. The program is designed to provide emergency foster care for youngsters as an alternative to placement in group shelter facilities. Professional treatment parents are recruited and trained to provide emergency shelter care; staff and treatment parents work to assess the youngster and family, work toward resolving conflicts, arrange for needed services, and develop a plan for the next steps. The average of stay in a PRESS home is approximately six weeks.

o Pressley Ridge In-Home Program - Started in 1989, the In-Home Program is an intensive home-based treatment program designed to help families in crisis who are at risk of having a child placed outside the home. Staff work with families within their homes, providing teaching, counseling, advocacy, and other services that are needed to improve the family's ability to manage current and future difficulties.

The Pressley Ridge Schools is governed by a 35-member Board of Trustees which is comprised of locally powerful and influential individuals. The major role of the Board is in the financial and fund raising arenas. At the time of the site visit, the Board was planning a fund raising campaign to support a $2 to $5 million expansion project involving building a gymnasium and expanding office space. The Board meets monthly and is organized into smaller committees to oversee particular areas of agency operation. One Board committee is responsible for overseeing the PRYDE program, and program staff meet with the committee at least twice a year to keep members informed.

The Executive Director of The Pressley Ridge Schools is described as a charismatic leader who was instrumental in formulating the concept of the PRYDE program and in its implementation. The program leadership and staff characterize the agency administration as highly accessible and supportive. Any problems that the agency has grappled with over the last several years are attributed to "growing pains" resulting from the rapid growth of PRYDE.

Philosophy and Goals

The philosophy of the PRYDE program has its roots in the reeducation model developed by Nicholas Hobbs. The reeducation philosophy can be characterized as "nonmedical" and ecological, focusing on youngsters in all their environments. The philosophy is one which views troubled and troubling behavior primarily as a result of troubled and troubling life experiences and which views treatment as teaching.

PRYDE also is based upon the belief that treatment can be more effective when it takes place in natural environments. The program represents a movement away from treating youths in groups within institutions to treating them individually within the context of a normal family. The program contends that youngsters are likely to make greater progress more quickly in home settings. Further, it is predicted that treatment gains or learnings will be maintained with more vigor when the treatment/learning environments are more similar to normal home, school, and community environments. The PRYDE approach also assumes that foster parents can learn to be effective treatment agents for troubled youngsters, an assumption backed by research demonstrating that parents can be trained to change children's behavior. Thus, some of the basic beliefs which underlie the PRYDE program can be summarized as follows:

- Children's troubled behavior can change.
- Foster parents can learn to change children's behavior.
- Change takes place most effectively in normal environments of daily living (home, school, community).
- Treatment is teaching skills for effective living.

Within the family setting, the treatment approach used by the PRYDE program is behavioral, based upon measurable treatment goals which are monitored frequently. The behavioral or behavior analytic strategies employed by the program borrow much from the Teaching Family model of group home treatment first seen at Achievement Place in Kansas. Treatment is guided by a daily treatment plan implemented by the treatment parents and consisting of a set of specific goals which are tailored to each individual child's needs and problems. A point system or other type of motivation system is used to structure the daily treatment interventions as well as for accountability purposes. The behavior modification approach is considered highly flexible in that it can be modified in accordance with the individual needs and skill deficits of each child or population served. In addition to the systematic behavioral interventions implemented within the treatment home, the program relies upon the vast amounts of incidental teaching that normally take place within a healthy family environment.

In accordance with this philosophy, the PRYDE program strives to achieve several important goals:

- To provide troubled and troubling children and adolescents with a noninstitutional treatment alternative in home settings.

- To help children learn the social, academic, and coping skills needed to live in the community.

- To discharge children successfully to less restrictive settings.

- To reunite children with their families whenever possible.

These goals reflect the stated mission of the program which is to help seriously disturbed children gain the family and community skills needed to deal effectively with their problems so that they can successfully live in the community. The last goal, addressing family reunification, reflects the program's attempt to re-educate children and their original families so that family reintegration is possible. If this is not possible, the goal then becomes to discharge the youngster to a less restrictive setting than PRYDE, such as a foster home, adoptive home, or independent living.

Services

Although the PRYDE model of service delivery is the same across program sites, there are some variations in its implementation to account for the differences in environment and services systems among the three states in which it operates. The description of services that follows focuses primarily on the largest PRYDE branch, that in Pennsylvania.

Preplacement Phase - The vast majority of referrals to the PRYDE program (approximately 95 percent) come from the Allegheny County child welfare agency, Children and Youth Services (CYS). This agency serves as a "gatekeeper" for services to children in the area through the use of a Recruitment and Planning Resources Committee. The Committee is responsible for reviewing the cases of each child who is awaiting placement or at risk for out-of-home placement and determining the most appropriate level of care for that child. The Committee is comprised of a CYS resource manager, caseworkers, supervisors, and other CYS staff; others from the community who are involved with a particular child may attend the meeting at which that child's placement future is reviewed. If therapeutic foster care is deemed to be appropriate, the Committee refers the child to two or more potential providers. Thus, most referrals to PRYDE Pennsylvania have been carefully screened and reviewed through this mechanism. A few referrals originate with the mental health and mental retardation agency and with the juvenile court.

Referrals are handled by an Intake Coordinator who is responsible for initial review of all referral information and oversight of the preplacement phase of service delivery. The referral information required by the program includes a psychological or psychiatric evaluation, a social history, a description or checklist of the child's significant problems, a medical history, a description of the child's current functioning, and an academic profile.

The Intake Coordinator's first responsibility is to make an initial determination of the appropriateness of the referral. If the information provided by the referral source is insufficient for making this assessment, additional information may be requested. For example, the Intake Coordinator may request a more recent psychological or psychiatric evaluation or may contact therapists or teachers to obtain supplementary information. After reviewing the file, the Intake Coordinator makes a recommendation to the Site Director regarding the acceptability and appropriateness of the youngster for the PRYDE program. At this time, the referral source is notified of the acceptance or rejection of the youngster.

Most children referred to the program are accepted (98 percent or more), but only a small percentage (approximately 15 to 20 percent) are eventually placed in PRYDE treatment homes. This is attributable to the limited availability of treatment home placements and the inability to meet the increasing demand for therapeutic foster care services. Although there are other agencies in the area providing therapeutic foster care, many referral sources hold out for PRYDE, feeling that the program offers an exceptionally high quality of care. The program receives a sometimes overwhelming number of referrals (usually 200 or more each year) and typically has a waiting list for services ranging from 20 to 60 youngsters. At the time of the site visit, 30 children were approved for admission to the program and were awaiting placement. While waiting for treatment home placements, many children are placed in various types of institutional facilities, other foster care programs, or remain at home or in shelter for long periods of time. PRYDE regularly follows up on all children referred to the program to determine where they eventually are placed if a treatment home placement cannot be arranged.

Once accepted, the youngster is interviewed by the Intake Coordinator who introduces the program, assesses whether the child is amenable to the motivation system approach, and determines the child's preferences for a treatment family to begin the matching process. The child remains on the waiting list until a suitable treatment home is found. When a potential treatment family is identified for a youngster, the Intake Coordinator contacts the family and provides them with information about the child. An initial meeting is arranged, generally at a neutral setting such as a dinner visit at a restaurant. The child is accompanied by the Intake Coordinator to this initial meeting.

The next step in the preplacement process involves preplacement visits. Typically, youngsters have two overnight or weekend visits with the potential treatment family prior to solidifying the match. Following the preplacement visits, both the child and the treatment parents have the option of rejecting the match. Staff report that this is a rare occurrence. However, the youngster may feel uncomfortable with the family for some reason, or the family may feel that the child does not blend with the family or with other children in the family. In these cases, a different treatment family is sought for the child.

An important part of the preplacement process involves exploring potential school placements in conjunction with treatment home placements. In order for the placement to be viable, the program must be able to arrange for appropriate educational placements and special education services within the district. Ethnicity is another consideration in the matching process. PRYDE attempts to keep children in homes of the same race when possible because this naturally enhances the cultural identity of the youngsters.

The preplacement process takes approximately two to four weeks from the time of referral to placement. If substantial barriers are encountered or if the waiting list is particularly long, the preplacement process can take somewhat longer, up to three months. In most cases, only one child is placed in a treatment home. In both the Pennsylvania and West Virginia programs, no more than 25 percent of the treatment homes have two children. In West Virginia, it is somewhat more common to have sibling groups referred to the program. With the exception of sibling groups, placement of a second child in a treatment home occurs only after the treatment family has demonstrated sufficient success with the first child.

The Intake Coordinator is responsible for conveying all the information and insights obtained during the preplacement phase to the staff person, termed Parent Supervisor/Community Liaison (PS/CL) assigned to the case.

Intervention Phase - The treatment planning process takes into account all information learned about the youngster during the preplacement process as well as initial observations of the child. Additional data is provided by the results of the Achenbach Child Behavior Checklist which is completed by the child's most recent guardian and teacher. The PS/CL, PRYDE parents, county caseworker, natural parents, youth, and sometimes school personnel are considered part of the treatment team and are involved in designing the treatment plan. The overall treatment plan, called the Individual Program Description (IPD) consists of a list of general goals and the specific treatment components or services proposed as the interventions. The treatment plan must be completed within 30 days of admission, and interventions are reviewed continuously by the PRYDE parents and PS/CL. Formal treatment plan reviews are held every six months and involve all members of the treatment team.

As in other therapeutic foster care programs, the intervention is comprised of treatment within the treatment home, support to the treatment home, ancillary services, and services to natural parents. The treatment provided within the context of PRYDE homes is implemented by the PRYDE parents and guided by the IPD. Treatment goals address each individual child's problem behaviors and may include goals such as reducing verbal or physical aggression toward peers and adults, increasing impulse control and appropriate problem-solving skills, eliminating stealing or fire-setting behavior, or increasing adaptive daily functioning within family and community-based settings. To provide an example, the treatment goals established for a 13-year-old boy in the intensive PRYDE program in West Virginia are shown at the end of this section. The program attempts to concentrate on the most pressing problems first, such as stealing or fire-setting, and addresses other goals as the intervention progresses.

The overall treatment goals are broken down into smaller, highly individualized goals or specific daily objectives. These objectives, developed in behavioral terms, form the basis for the motivation system developed for each child. The program begins each child on a point system which lists an array of targeted treatment objectives. Three categories of objectives are included in the motivation system: treatment objectives, social/emotional development objectives, and maintenance objectives which include such things as housekeeping chores and self-care. At least 40 percent of the behaviors included in the point system must be treatment behaviors. For each objective or behavior included in the motivation system, point values are assigned to show how many points the youngster receives for demonstrating the desirable, adaptive behavior and how many points will be lost for the opposite behavior.

Tracked and documented by the treatment parents, the youngster earns or loses points based upon his or her behavior. Treatment parents use point loss episodes as opportunities for therapeutic teaching and counseling. For younger children, physical tokens of some type (checkers, chips, or stars) may be used to help the child to concretely see progress. The total accumulation of points during each day determines the youngster's level of privileges for the following day. The privileges and special activities given to the youngster based upon point earnings are highly individualized, and are determined by the child's interests and developmental level and by the home's standard rules.

Pryde parents are required to complete the point sheet on a daily basis along with a Log of Daily Events (LODE) which documents the use of critical parenting skills and summarizes the youth's performance for that particular day. Treatment parents typically spend some time with the child on a daily basis reviewing the day's events. This interaction serves to encourage the child to keep up the good performance or to improve on subsequent days. Point sheets and LODES are reviewed by PS/CLs regularly, providing data to evaluate the youngster's progress and to revise the intervention. The data from the point sheets and LODEs are summarized on graphs every two weeks, allowing PRYDE parents and PS/CLs to readily assess the youth's progress. A sample point sheet and LODE are included at the end of this section.

Both the treatment plan and point system are revised as some problems are eliminated and others appear. Youngsters who have shown consistent progress on a daily point system over time are shifted to a merit system. The less structured merit system involves tracking progress on a set of specific objectives and rewarding overall performance at the end of each week. Thus, as the youngster progresses the daily structure of treatment is reduced in anticipation of discharge to home or alternative living situations with less structure.

PRYDE parents also teach youngsters problem solving skills and the information and skills needed to facilitate positive social relationships with peers. Beyond the behavior management and formal teaching that occurs in treatment homes, much informal "counseling" also occurs and benefits derive from being in a consistent, healthy family setting.

A range of supports are provided to the treatment home by the PRYDE program. Of primary importance is the support provided by staff. PS/CLs call treatment homes daily after a child is placed in a treatment home to check on the child's adjustment and to assist the PRYDE parents. Close telephone contact with treatment parents, an average of two calls per week, is maintained on an ongoing basis to respond to questions, concerns, and problems and to provide supports. Additionally, PS/CLs visit treatment homes weekly at a time that is convenient to treatment families. The home visits, which may last from one to four hours, are seen as a continuation of training. The training or consultation provided by PS/CLs is highly individualized and tailored to the specific challenges presented by the youngster in placement. Home visits typically involve discussing the child's progress, sharing successes, dealing with problems, providing technical advice, and exchanging and reviewing paper work. The PS/CL also uses home visits to build a positive relationship with the child. While the PS/CL is not considered the child's counselor per se, an informal counseling relationship may develop and the PS/CL may take the child to dinner or a movie or on another outing. The primary role of the PS/CL is as a helper and supervisor for the treatment parents.

An essential support provided to treatment homes is crisis assistance. The program tries to avoid crises by remaining alert to developing problems and by intervening early. However, when crises arise, a 24-hour hotline service ensures that a staff person is always available by phone to respond. Staff rotate on-call responsibilities. In Pittsburgh, for example, each PS/CL is on call for approximately one week per month and covers all cases served by his or her team. In this way, the on-call staff person is familiar with the youngsters and families supervised by team members. An answering service is used and the on-call staff person carries a pocket pager. There is a list of events for which treatment parents are required to notify the program via the hotline immediately such as a personal injury, an emergency hospital visit, physical aggression, sexual misconduct, possession of weapons, suicide threat, or runaway. Some crisis calls result from the treatment parents' need to share problems or overwhelming frustrations.

If telephone support and consultation is not sufficient to respond to the crisis situation, a crisis team is sent to the home. The crisis team generally includes the PS/CL and another staff person. The second person on the crisis team often is determined by the nature of the crisis. If substance abuse is involved in the crisis, a staff person with special expertise in this area may be asked to join the crisis team. The PRYDE parents and crisis team collaborate to assess the situation and design an intervention plan. Intensive support from the crisis team may continue throughout the crisis resolution period. Every attempt is made to keep the youth in the original treatment home while resolving the crisis. In some cases, staff and PRYDE parents may decide mutually that the child needs to be out of the home temporarily in an emergency respite care situation or some other setting.

Hospitalization for a child in crisis is considered by PRYDE to be the last resort. Hospitalization is considered only when the program can no longer assure the safety of the child, even with the addition of extra staff within the treatment home to provide 24-hour supervision. Due to these efforts to avoid hospitalization, PRYDE youngsters are hospitalized infrequently. In Pittsburgh, approximately five or six youngsters are hospitalized annually out of a client population numbering 65. If a youngster is hospitalized, he or she is not discharged by PRYDE. Rather, PRYDE works closely with psychiatric personnel and other hospital staff toward returning the child to the PRYDE home.

In West Virginia, where there are few resources for emotionally disturbed youngsters, the program is forced to use creative responses in crisis situations. For example, a youngster who attempts suicide would be brought to the local hospital emergency room. Since there are few emergency psychiatric beds for children and adolescents, other arrangements for care and supervision must be made. If the youngster is admitted to the hospital, the program often is required to set up a suicide vigil with the PRYDE parents, PS/CL, and others taking shifts to provide constant supervision. Aides might also be paid by the program to remain with the child at the hospital or at the PRYDE home.

Some crises are precipitated by incidents involving threatening or violent behavior among youngsters in treatment homes. On rare occasions, youngsters have committed seriously destructive acts including sexual assault, physical assault, and fire setting. These crises have been resolved favorably in nearly all instances, with the PRYDE parents remaining with the program. While the offending child was removed from the PRYDE home (or even the program) in some cases, most often the offending child has remained within the treatment home with appropriate consequences for the offense as well as additional services.

Respite care is another support provided to treatment homes. Respite care provides a break from the often stressful, 24-hour responsibilities of treatment parenting and is an important tool for preventing burnout. The program attempts to use respite care primarily on a pre-arranged basis and to avoid using respite care during crises based on the belief that problems in the treatment home should not be resolved by removing the child. The program provides respite care by paying treatment parents to provide these services; some treatment parents provide respite care only. Typically, there is one respite family available for 10 families. Many treatment parents also provide respite care for each other, stemming from the close ties that families develop with each other through the program.

The PRYDE program provides a variety of ancillary services based upon the individual needs of each youngster. These may include:

o Mental Health Services - PRYDE parents are considered the primary agents of treatment, and treatment within the treatment home is considered the primary intervention. Accordingly, the majority of youngsters do not receive counseling outside of the treatment home. Approximately 25 percent of the youngsters in Pennsylvania do receive some type of counseling outside the home, generally provided by staff or graduate students within the Pressley Ridge agency. A smaller percentage of youngsters, 10 to 15 percent, receive mental health treatment from sources external to the agency, a policy which helps to ensure consistency in treatment philosophy and approach. Counseling or therapy outside of the treatment home is arranged for children under several well-defined circumstances--when therapy was started prior to entering PRYDE and there is an established relationship with a professional; when specialized counseling for sexual abuse, substance abuse, or another special problem is indicated; or when counseling at a mental health clinic is required by a previous county plan. Psychiatric evaluation and ongoing follow-up is available to youngsters needing such services; approximately 15 percent of PRYDE youngsters are likely to be on some type of psychotropic medication.

In West Virginia, a greater percentage of youngsters receive additional counseling through community resources, in many cases as a result of court orders. In addition, about 20 percent of the youngsters in the West Virginia program receive psychiatric services from the program. In Maryland, the majority of the children receive outside counseling. Both of these program branches indicate difficulties in ensuring the primary role of the treatment parents as well as treatment consistency when external sources are used to provide counseling.

- School Support - The PRYDE program attempts to coordinate services closely with the schools. The Intake Coordinator usually is the first person to approach the schools about a particular child who will be placed in the district, beginning the process of advocating for the child's needs and rights to special education services. PRYDE parents and PS/CLs are then responsible for ongoing coordination with the school, keeping school personnel apprised of the child's progress, assisting the school with any problems, and coordinating home and school interventions.

  Program managers and staff report that the schools present the most difficult interagency coordination problems faced by PRYDE. In Pittsburgh alone there are more than 25 separate schools districts, and staff must interact individually with each one. Some school districts are receptive to serving youngsters in therapeutic foster care, while others resent foster children coming into the district and see them as "someone else's problem." It takes considerable time and effort on the part of staff and treatment parents to work with the schools.

  Many of the youngsters in the PRYDE program require special education services of some type. While about 39 percent are mainstreamed in community schools, approximately 30 percent are classified as severely emotionally disturbed, and 13 percent are classified as educably mentally retarded. In some cases, a child cannot function in a public school setting, cannot get into the school district of the treatment home, or special education services are not available in that district. In these situations, the Pressley Ridge Day School is used as an educational placement. The program reports that it is extremely helpful to have a back-up educational setting for therapeutic foster care programs to use when arrangements or placements with the public schools are inadequate. Approximately 10 to 20 percent of PRYDE Pennsylvania youth attend the Pressley Ridge Day School.

- Medical, Dental, and Family Planning Services - In Pittsburgh, the program has arranged for medical and dental services through a contract with the Allegheny General Hospital. Treatment parents can use private providers if the providers accept Medical Assistance. Planned Parenthood is used to provide birth control services to PRYDE youth when needed. In-service training sessions on sex education are held for treatment parents, and the program has held sex/birth control education workshops for adolescents. If a pregnancy is suspected, the youngster must receive counseling on all options. There have been several pregnancies, and most of the youngsters have remained in their treatment homes. Some have kept their babies in the treatment homes as well until they were ready to be discharged to independent living with the child. In some cases, the child was ultimately separated from the adolescent parent.

- Recreation - The program expects that each PRYDE youngster will participate in recreational activities, both organized and informal. PRYDE parents are responsible for ensuring that each child has access to recreational activities appropriate to his or her age, making the greatest possible use of available community resources. Typically, PRYDE youths become involved in community organizations such as Boy or Girl Scouts, church youth groups, or sports. Recreation is stressed by the program due to the contention that positive peer selection is an important determinant of the future adjustment of PRYDE youngsters.

Services to natural parents comprise another major aspect of service delivery. PRYDE's approach to working with natural families is described in the following section.

Discharge and Follow-Up Phase - The average length of treatment in PRYDE typically ranges from 12 to 18 months. Planning for discharge is begun well in advance. A discharge plan with specific goals is devised, indicating the anticipated discharge placement and what must be accomplished to enhance the likelihood of stability following discharge. In preparation for discharge to less structured settings, the motivation system initially used to structure the intervention may be phased out. As noted, youngsters often are shifted to a merit system which consists of a simple checklist of behaviors which must be maintained 90 percent of the time. If necessary, the PRYDE parents may revert to a point system in response to a particular problem. Eventually, the merit system may be phased out as well.

One of the basic goals of PRYDE is to discharge youngsters to less restrictive settings. For the many youngsters returning home, PRYDE concentrates significant effort on working with natural families to ensure that they are ready for reunification. Staff and natural families focus on basic needs such as adequate housing and income as well as on teaching natural families the skills needed to work effectively with their children. In some cases, natural parents are taught to use simplified point systems. Additionally, meetings are held with the entire family, including siblings, to prepare for the adjustment and stress of reunification.

For youngsters who cannot return home, regular foster care, adoption, or "step-down" services with PRYDE are possible outcomes. PRYDE parents typically do not adopt youngsters or provide long-term foster care placements. The program is clearly defined as a time-limited treatment intervention and is reluctant to lose highly trained and skilled treatment parents. However, about one-third of the children in PRYDE Pennsylvania remain with their PRYDE families on a longer-term basis, more than two years. In many cases, the homes convert to step-down PRYDE homes with less intensive services. While the payment to PRYDE parents remains the same in step-down homes, the per diem cost to the counties is reduced due to the lower cost of administering and supervising the less intensive level of service. One PRYDE child was adopted by the treatment parents, and several other adoptions are in process. However, these cases are the exception, and the program tends to discourage permanent placements in treatment homes.

For youth nearing the age of emancipation, independent living may be the placement of choice upon discharge from PRYDE. PRYDE makes use of independent living programs in the area but also uses PRYDE parents to prepare youth for independent living. In the context of treatment homes, parents work with youngsters to address issues related to emancipation and to learn the skills needed for independent living. The skills taught are based upon an Independent Living Skills curriculum developed by the program to assist treatment parents in this area. For example, a youth in a PRYDE home may be linked with a vocational education or preparation program while working with his treatment parents at home to learn daily living skills. Treatment parents often help youngsters locate apartments and jobs and may continue to provide supervision and support following the youth's move. In West Virginia, a more formalized arrangement for independent living services has been arranged. The state pays the regular foster care rate to PRYDE. PRYDE, in turn, subsidizes a youth in an apartment setting and the PS/CL and treatment parents provide supervision and continue to work with the youth on independent living skills.

During a 12-month period, 37 youngsters were discharged from PRYDE Pennsylvania. Approximately half of these youngsters were discharged to their parents or to relatives (18 children or 49 percent); 15 went to independent living situations (40 percent); 3 went to foster care (8 percent); and 1 child (3 percent) went to a psychiatric hospital.

Whatever the discharge placement, the program provides follow-through services for a period of 12 months. The follow-through component is based upon the recognition that the transition to home or to a new environment can be a difficult one. Follow-through services are provided to enhance the likelihood that youngsters will do well after they leave treatment homes. For the first six months, weekly phone contact is made with the child and family as well as at least one face-to-face contact per month. For the second six-month period, the program continues to contact the child and family monthly to check on progress and to respond to any problems.

Depending upon the particular case, either the PS/CL or the PRYDE parents are assigned to provide the follow-through services. PRYDE parents are paid $5 per day for three months if they take lead responsibility for providing and documenting the follow-through services; this arrangement can be extended for an additional three-month period.

In addition to these follow-through services, natural parents are encouraged to continue attending the natural parents' group indefinitely. Further, due to the strong relationships and bonds that develop between PRYDE parents and youngsters, much follow-up contact occurs naturally. Youngster and treatment parents often remain in contact by telephone, and visits (even overnight or weekend visits) may occur periodically. In one case, a youngster spent one weekend each month with his PRYDE family for a period of time following discharge. Contact often is maintained for many years following discharge.

Services to Natural Parents

The natural families of PRYDE youngsters generally have multiple problems and long histories of involvement with social service and mental health agencies. Referral materials reveal that the vast majority of natural families live in poverty (90 percent), with annual incomes below $10,000. Over 60 percent are single parents, and significant percentages of natural parents have problems including alcohol abuse (45 percent), drug abuse (23 percent), mental illness (21 percent), histories of physical or sexual abuse of their children (45 percent), or poor parenting skills (75 percent).

Initially, PRYDE's approach to working with natural parents relied solely upon individual assessment and intervention by the PS/CLs. Similar to the experience of other therapeutic foster care programs, PS/CLs were often frustrated in their efforts to engage natural parents in the service delivery process. Parents often were inaccessible, resisted scheduling meetings, missed appointments, and failed to follow through on agreements. The difficulties in involving natural parents and the slow progress led to a neglect of this aspect of service delivery. At one time it was found that PS/CLs made eight times as many phone calls and four times as many visits to treatment families than to natural families, a situation attributed directly to the high level of effort required and the little success achieved in working with natural families.

In response to the inconsistent work with natural parents, PRYDE developed a new model for natural parent services. The approach is based on the goal of facilitating the best possible relationship between the child and natural parents, whether or not the family ultimately will be reunified. Because many families are resistant to yet another agency and caseworker, PRYDE staff members avoid approaching parents as authority figures but rather invite them to become involved as a member of the treatment team.

PS/CLs continue to work individually with natural parents. Home visits are made at least once per month, with more frequent phone contact. PS/CLs always contact natural parents promptly after a youngster has a home visit to review the visit and discuss any problems that may have arisen. In addition to the individual work by PS/CLs, PRYDE implements natural parents' groups. The natural parents' groups meet every two weeks in the evening. In Pittsburgh, the program runs two groups, each with membership ranging from 6 to 18 people over the years. Initially, structured behavioral skills training was attempted for natural parents, but results were marginal. Currently, the group process is designed to maximize parent participation and to help participants identify and take "the next small step in their relationship with their child."

Each parent in the natural parents' groups has a treatment plan which specifies a series of objectives. The parents develop their own treatment plans with the assistance of staff; goals may relate to their children or may focus on the parent's individual problems or issues. Examples of objectives that may form a natural parent's treatment plan include:

- Write or call child regularly.
- Improve relationship with other children at home.
- Improve own self-worth by doing such things as developing hobbies or going to church.
- Learn ways of handling child better.
- Complete a job training program and get a better job.

Through PRYDE's experience, a series of features has been designed which contribute to the success of the natural parents' group:

- Family attendance by invitation only - PS/CLs assess which natural parents would be receptive to and appropriate for group meetings; only these parents are invited to participate in the natural parents' group. (Attendance was limited after the program found that some parents showed little response to any of the interventions and that their presence in the group appeared detrimental to the other parents. These individuals typically evidenced severe problems of substance abuse or manifested criminal behavior and were verbally assaultive toward professionals.)

- Public, realistic, written commitment to attend and participate - Natural parents are asked to sign an agreement indicating that they will attend the next five group meetings and will keep the basic rules of the group. The group's rules require that parents arrive "straight" and not under the influence of alcohol or drugs and that they maintain confidentiality. After each series of five meetings, the parents may be required to sign a new contract committing them to participate in the next five meetings.

- Prompts before meetings - The program provides letters to remind participants about upcoming group meetings. The day before or on the day of meetings, the group leader makes personal phone calls to remind participants and to encourage them to attend.

- Transportation supports - To assist parents who have transportation problems, van service is provided to meetings from a central downtown location. If the van service is inconvenient, parents are reimbursed for the bus fare needed to attend the group.

- Babysitting supports - PRYDE hires a teenager to supervise and entertain children in another room close to the meeting room. This enables natural parents to attend the group without worrying about arranging and paying for child care.

- Refreshments - The food served at group meetings is reported to be a feature that is very popular among participants. Attendance at meetings often is the only social outlet for many parents. The opportunity to share refreshments and to socialize is enjoyed and appreciated.

- Dinner visits - Arrangements can be made for natural parents to meet their PRYDE children two hours prior to the group meetings. The agency provides dinners for the parents and youngsters, providing them with an opportunity to spend some time together in an informal, relaxed atmosphere.

- Defined staff role - A PRYDE staff person is assigned as group leader and is responsible for maintaining the flow during each session and for maintaining the focus on the parents' objectives. Another staff person assumes the role of logistics manager, with responsibility for all planning tasks between group meetings.

- "Empowering" group process - The group process is designed to minimize the threat to natural parents without eliminating all demands of them. Parents choose their own goals and are encouraged to take responsibility for their own actions. Goals are broken down into small, achievable steps, so that parents do not feel unduly pressured and can experience success during the two-week time period between meetings.

- Starting "where the parent is" - The initial goals of a parent may not be directly related to the child's adjustment. For example, parents may focus on housing problems, marital problems, employment problems, or lack of a social support network. The goals and action steps are structured to address the most pressing problems presented by natural parents, from their own perspective. Specific parenting skills needed to work with their child are taught only when parents are ready and when this is relevant to their current concerns.

Using this group process, attendance at natural parents' groups has risen markedly, high levels of participation in group sessions has been achieved, and a significant number of objectives have been completed by natural parents. Parents tend to see the group as a combination therapy and support group. Participants report that they can be frank about their problems, lean on each other, and get constructive criticism from each other and from staff.

Despite the success of the individual and group work, many natural parents do not become involved. Approximately 20 to 40 percent of the natural parents are not involved in services at all. Their rights may have been terminated or they may refuse involvement for other reasons. In PRYDE Pittsburgh, approximately 25 percent of all parents attend the natural parents' group. In 1989, PRYDE Sewickley was able to involve 37 percent of all families in that area in support groups. Natural parents who do not participate in the groups are seen individually by PS/CLs on a regular basis. For parents who resist involvement with the program, a monthly letter is sent by the PS/CL to update them on their child's progress.

In West Virginia, the logistics of group work with natural parents are difficult due to the geography and distances involved. With parents spread out in rural, isolated areas, travel to a central location for group meetings is impractical. Thus, the West Virginia program relies on individual services to natural parents provided by PS/CLs.

In addition to working with PS/CLs and the group, natural parents often develop a supportive relationship with treatment parents. PRYDE parents may talk with natural parents each time the child calls home and, over time, a relationship based upon mutual support and sharing may evolve. While this type of relationship is considered ideal, in some cases natural parents have harassed or subverted treatment parents, for example, by encouraging the child to run away. Staff work with natural and treatment parents to attempt to resolve these situations.

Networking and Linkages

Close programmatic relationships within The Pressley Ridge Schools ensure that PRYDE children receive priority for needed services such as the Day School or the Wilderness School if this becomes necessary. In the larger community, PRYDE constantly nurtures its relationships with other agencies. Staff emphasize that a continuing educational process is needed to convince other agencies and would-be referral sources that therapeutic foster care is a viable and effective treatment approach for severely disturbed youngsters. Turnover at other agencies often frustrates the program's attempt to educate and maintain collaborative relationships.

One of the most important and difficult linkages is with the schools. The relationships with the numerous school districts in the area are handled individually by PRYDE parents and PS/CLs rather than at an agency level. Program leaders and staff are troubled by the often-encountered resistance to taking troubled youngsters into certain school districts and to providing for their special needs. This resistance has proven difficult to overcome. PRYDE staff periodically offer inservice training sessions for school personnel, a way of building positive relationships and assisting the school in coping with seriously disturbed youngsters. In order to minimize problems in obtaining educational placements for youngsters, staff are well-versed on the education laws that protect the child and the placement process including the records that are needed to expedite educational placement. For troublesome cases, the assistance of education law advocacy groups may be enlisted.

A vital linkage for PRYDE is with Allegheny County Children and Youth Services -- the primary referral source to the program in Pennsylvania -- and with the child welfare agencies in the other areas. Caseworkers are considered part of the treatment team and are closely involved in treatment planning and decision making for PRYDE youngsters. Ongoing communication with the caseworker is considered essential, and the caseworker is notified and asked for input regarding any critical incident or decision in the child's life. Additionally, PRYDE keeps caseworkers informed through quarterly progress reports, frequent telephone updates, and staffings held every six months. Conversely, caseworkers are asked to keep PRYDE fully informed about the family's history, any changes in the family's circumstances, court dates, likely discharge plans, and the like. Administrative meetings are held on a regular basis involving managers from PRYDE and the child welfare agencies to discuss and resolve any identified problems that cannot be solved at a staff level.

In addition, PRYDE attempts to work closely with juvenile court judges and the juvenile justice agency. Staff attend court hearings and case reviews and act as advocates for children. While PRYDE has physical custody of the child, it is the CYS caseworker and advocate lawyer who formally represent the case at hearings. It is, therefore, incumbent upon PRYDE staff to keep the caseworker and advocate fully informed about the child's progress.

Representatives of PRYDE participate actively in organizations involved in advocacy regarding children's services such as the Pennsylvania Council of Voluntary Child Care Agencies, a providers' organization, and the Children's Council of Allegheny County. The Children's Council meets several times a year and is comprised of child-serving agencies, hospitals, professionals, and citizen advocates. The group focuses on reviewing the services available to children in the county, identifying service gaps, and advocating for additional services.

Clients

PRYDE describes the population served as "troubled and troubling" youngsters. Initially, the program focused on serving adolescents. As it became established, PRYDE broadened the population served, accepting younger children and those with more varied problems. Currently, the program indicates that it serves some of the most difficult and needy children, many of whom have been rejected by other agencies and have failed in other treatment facilities.

The population served by the PRYDE programs in Pennsylvania and West Virginia ranges in age from 4 to 18, with an average age of about 13.5. Data on a sample of 149 youngsters served by PRYDE in Pennsylvania and West Virginia between 1985 and 1987 indicate that the program serves slightly more males than females (52 percent and 48 percent respectively). A significant percentage of the youngsters served are black (44 percent), due primarily to the large population of black children served in Pittsburgh. White youngsters account for 54 percent of the population, and the remaining 2 percent is comprised of small numbers of Hispanic and Asian clients. On the average, youngsters first left home at the age of nine and have experienced an average of 3.2 previous out-of-home placements prior to entering PRYDE. Thirty percent of the youngsters have a past history of psychiatric hospitalization. More than half of those served by the program have been victims of either physical or sexual abuse.

Youngsters enter the PRYDE program from a variety of settings. Data from 1985-86 show that the placements immediately prior to entering PRYDE include youth care institutions of various types and group homes (36 percent), regular foster care (24 percent), psychiatric facilities (20 percent), and natural or extended family homes (20 percent). While the program does not emphasize diagnoses, the vast majority of youngsters are characterized as having conduct disorders. A sense of the types of problems manifested by PRYDE clients can be derived from the detailed information collected describing presenting problems. The following list indicates the percentage of youngsters in the 1985-1987 sample with each type of problem.

Aggressive toward children	64%
Aggressive toward adults	60%
Dishonest	48%
Poor self-concept	45%
School problems (academic)	35%
Depression	34%
Overly dependent	37%
Tantrums	31%
Property destruction	29%
Sexual problems	26%
School problems (social)	26%
Running away	23%
Hyperactivity	22%
Hallucinations/mood swings	22%
Encopresis/Enuresis	15%
Drug abuse	13%
Medical problems (psychiatric)	7%
Suicide attempts/threats	9%
Mentally retarded	11%
Medical problems (physical)	9%
Self-destructive	7%

The program indicated that it generally does not accept youngsters who are extremely violent, actively psychotic and unstabilized, sexual offenders, severe substance abusers, or fire setters. Program managers and staff are quick to point out, however, that PRYDE has, in fact, served youngsters with **all** of these problems. Admission decisions are based on the degree and recency of the behavior and staff judgments as to whether the behavior presents an unacceptable risk for the treatment family or community. Staff are convinced that with additional resources and program supports, many children considered dangerous to themselves or others could be successfully served within the context of treatment homes. Such additional program supports might include highly skillful treatment parents, staff assistance in the treatment home, and even home modifications to ensure security for the child and others.

The ability to serve severely disturbed youngsters has been demonstrated by the PRYDE program through several special projects. As noted, the West Virginia Office of Health requested that PRYDE attempt to serve youngsters who were in out-of-state institutions. The result was the intensified version of PRYDE in West Virginia, which provides additional training for treatment parents, in-home aides to assist each family, increased staff supervision, and additional psychiatric, educational, and other supports.

The Allegheny County Office of Mental Health/Mental Retardation funded a pilot project to provide therapeutic foster care services to three youngsters with the dual diagnosis of both mental health and mental retardation, with the goal of avoiding institutionalization. PRYDE located and trained treatment families specifically for these children and successfully served them in the context of treatment homes. One of the youngsters served through this pilot was 17 years old, psychotic and retarded, and legally blind. This youngster had been in and out of state and community hospitals throughout his life, but was stabilized in a PRYDE home. The success of this pilot led to the implementation of Home Places, a therapeutic foster care program operated by The Pressley Ridge Schools to serve this dually diagnosed population.

Although sexual offenders typically are excluded from therapeutic foster care programs, PRYDE Pittsburgh has successfully worked with at least two adolescent male sex offenders, both age 14 with histories of repeated sexual assaults against younger children. Special interventions were developed to target the sexual assault behaviors, and the results were positive; neither boy is suspected of any further sexual misconduct.

Youngsters served by PRYDE are usually in the custody of the child welfare agency. Parents do not relinquish parental rights, but are required to relinquish custody to the agency in order to participate in the program and receive full financial assistance. According to the program, parents have done this freely.

Staffing

In the PRYDE program, one professional staff person coordinates all aspects of the intervention program for each youth. Staff are called Parent Supervisor/Community Liaisons (PS/CLs) and have diverse functions including preservice training of treatment parents; in-home supervision and training of treatment parents; individual assessment and informal counseling of PRYDE youth; inservice training of treatment parents; training and counseling of natural parents; and advocacy for youth in schools, courts, and community. The typical caseload for PS/CLs is six to seven youngsters, their treatment families, and their natural families. While the Children and Youth Services caseworkers are the official case managers, their caseloads often exceed 40 children per worker. Thus, PRYDE staff typically assume the primary case management role for youngsters in the program, fulfilling the service coordination and liaison functions.

All PRYDE programs are staffed by a site director, one PS/CL for every six to seven cases, part-time clinical consultants, a secretary, and assistance from central administration to handle general administration, contracts, financial accountability, and evaluation tasks. Once a program is serving about 25 children, it will also have program supervisors to assist with the supervision of PS/CLs and other administrative tasks. Additional secretarial staff, a part-time parent evaluator, and an intake coordinator also are added as a program reaches this size. For example, PRYDE Pittsburgh (serving 60 youngsters) has a site director, two program supervisors who supervise four to five PS/CLs each, an intake coordinator, a clinical coordinator, a part-time parent recruiter/trainer (a PS/CL with a reduced caseload), two secretaries, and one evaluator for both parent and program evaluation.

The staff in Pittsburgh is organized into teams of four to five PS/CLs, each with a supervisor. An attempt is made to balance teams with an appropriate mix of new and experienced staff. The value of teams, according to the program, lies in enhancing the sense of belonging among staff and in providing a natural structure which offers mutual support and supervision. Additionally, team members become familiar with each other's cases and are able to provide emergency coverage for each other through a rotational on-call system. Teams meet weekly for supervision and case consultation; informal supervision and consultation is available to staff at any time.

While there are male PS/CLs, the preponderance are female. In addition, most staff are white, resulting in a concerted effort to recruit more minority PS/CLs, particularly in Pittsburgh. This effort has resulted in an increase in minority professional staff. PS/CLs are about evenly split between the bachelor's and master's levels, with degrees in disciplines including counseling, psychology, social work, sociology, special education, criminal justice, and rehabilitation counseling. Master's level PS/CLs with one to two years of relevant experience are considered ideal. The program looks for individuals who have had some training or experience with behavior analysis. It is possible for experienced and highly skilled PRYDE parents to become PS/CLs after a period of time, and the program has, on occasion, waived educational requirements and placed staff on probationary status while they complete the required bachelor's or master's degrees.

In addition to academic training and relevant experience, PRYDE looks for staff who can fulfill the many and diverse roles required by the program and who approach the job with enthusiasm and commitment to the PRYDE model. While academic degrees are of some importance, the program contends that a set of personal characteristics are essential for the PS/CL job. Accordingly, the program looks for individuals who are energetic, enthusiastic, secure, personable, resourceful, assertive, resilient, proactive, and able to tolerate high stress challenges, frustration, and failure. Additionally, staff must have few deficits in their own personal lives and good communication skills as well as "a sense of mission." PRYDE staff also must have their own cars due to the tremendous travel required to work in the field with treatment families, natural families, and community agencies.

The staff is supplemented by students, both undergraduate practicum students and clinical psychology or social work graduate students. The undergraduates may be in either part-time or full-time placements and typically work with the Intake Coordinator. Graduate students usually spend half of their time doing direct clinical work with children and the other half of their time engaged in some type of research or program evaluation activity.

The program noted that new staff with traditional training or experience may be used to the office-based, 50-minute hour clinical approach to working with youngsters and families. Significant reorientation and training may be required to adjust to the PRYDE model involving outreach to homes and the community. New staff typically are trained by working closely with an experienced partner and other team members and supervisors. A new staff person accompanies an experienced PS/CL to every type of event (home visit, school meeting, court appearance, etc.) before handling these situations alone. A new staff person may begin by carrying one case with extensive supervision prior to assuming full caseload responsibilities. Completion of a detailed training curriculum for PS/CLs is required for new staff, and they must read all treatment parent training materials as well. In addition, all staff are required to attend advanced training workshops which focus on counseling skills and motivation systems.

A range of inservice training opportunities are available to PRYDE staff. About one hour each week is devoted to staff training, including individual training in supervision meetings and formal training workshops conducted by agency staff or consultants. Examples of the topics addressed in these workshops include current child sexual abuse laws, suicide, runaways, and presenting in court. In order to enhance the behavior analytic skills of staff, the program periodically offers a weekly seminar on behavior analysis which focuses on field applications of behavioral principles. Each staff person, including clerical staff, is provided a $600 educational benefit by the agency for job-related training. Two PRYDE staff persons took 13-week training courses on sexual abuse interventions with the assistance of this benefit.

The most unique educational opportunity offered by PRYDE is a master's degree program in special education with different areas of specialization including teaching or community administration -- an area often chosen by PRYDE staff. Faculty of the California State College in Pennsylvania teach the courses at the Pittsburgh campus in the evenings. Staff use their educational benefit for tuition, and the agency pays the faculty members to come to the agency to teach. At the time of the site visit, 10 Pressley Ridge staff persons were participating in the three-year program.

Prior to 1985, PRYDE experienced a very low turnover rate among staff. However, in 1985 the program experienced a 50 percent turnover rate among PS/CLs. Staff turnover is particularly damaging in therapeutic foster care programs. With many new staff persons, treatment parents tend to be more knowledgeable than the staff assigned to supervise and train them. The high turnover rate prompted PRYDE to seek outside consultation to analyze and review the PS/CL job design and to offer recommendations. The recommendations included:

- Stabilizing caseloads at six or seven since high levels of stress are associated with larger caseloads.
- Providing more attractive starting salaries and pay ranges for PS/CLs.
- Ensuring an appropriate array of supporting clinical services to supplement PRYDE parents and PS/CLs including therapists, sexual abuse specialists, and others.
- Providing reliable respite care options, especially for crisis situations.
- Upgrading degree and experience requirements for PS/CLs.

Through this analysis, PS/CLs noted that the principal frustration of the job lies in the unpredictability of events and the inability to plan ahead personally or in terms of work load. Further, PS/CLs noted that PRYDE can "become your whole life" and that the opportunity for burnout is significant. High turnover persisted for a two-year period while some of the above recommendations were implemented, including a 25 percent increase in the starting salary range.

The PRYDE program uses many strategies to minimize staff burnout and reports that morale currently is high. First, the teams offer nurturing and supportive structures for staff. Additionally, the program encourages flexible scheduling and allows each staff person to take a long weekend each month. Social functions for staff are held periodically, and special efforts are made to recognize staff achievements, for example, through "staff person of the month" awards. Further, the program emphasizes the achievement of personal goals by staff whether these relate to health, hobbies, or professional development.

Treatment Parents

PRYDE currently has approximately 90 active treatment families in Pennsylvania, 50 in West Virginia, and 25 in Maryland. The age of treatment parents ranges from 21 to 56, and their average age is about 39. Most are married and have been married for significant periods of time before becoming involved with PRYDE. Single treatment parents (15 percent in Pennsylvania) are required to have a friend or relative become certified with them in order to serve as an assistant parent. Although the program does not eliminate single parent applicants, it reports that single treatment parents generally are not as successful and tend to burn out more quickly than couples. Treatment parents tend to be well-educated, with approximately 65 percent having some post-high school education or training. They also tend to be comfortably employed, and the median income of treatment parents falls between $25,000 and $30,000. Many treatment parents represent people who want another income in the family but prefer not to work outside the home. In Pennsylvania, treatment parents are 55 percent black, while in West Virginia they are 95 percent white, reflecting the population make-up of these respective areas.

PRYDE recruitment efforts target people who are well-adjusted, have good parenting skills, strong morals, and the ability to love and relate well to children. The individuals sought for treatment parenting tend to be interested in the job as a means of furthering their own personal and professional growth as well as of helping a child in need. Because recruitment efforts target these types of individuals, the mainstay of PRYDE's recruitment strategy involves vigorous outreach and education efforts in the community, particularly in places where interested individuals are most likely to be found.

In Pennsylvania, a half-time Recruitment Coordinator bears most of the responsibility for ongoing recruitment activities although all staff and treatment parents are expected to contribute. In other sites, staff share recruitment tasks. Typically, the program orchestrates intensive recruitment campaigns four times a year, each lasting for four to five weeks and combining a number of different recruitment strategies. At a lower level of intensity, recruitment efforts continue throughout the year.

Media advertising and mailings are among the recruitment strategies used by PRYDE. However, an analysis of recruitment patterns revealed that only 6 percent of PRYDE parents in Pennsylvania were recruited by mailings or media. The largest proportion of treatment parents were directly recruited by active treatment parents, and 34 percent were recruited by word of mouth. Since such a significant percentage of new treatment parents are recruited by current parents, the program encourages and facilitates this approach by sponsoring recruitment parties/presentations at the homes of active treatment parents and by offering finder's fees for recruiting new parents. Staff emphasized the importance of recruiting high quality treatment parents at the outset, since future treatment parents are likely to be acquaintances, colleagues, friends, or relatives of existing treatment parents.

A variety of strategies are used to recruit treatment parents:

o Introductory presentations (parties) held in the homes of current treatment parents. Refreshments are served and staff and treatment parents provide information about the program.

o Paying PRYDE parents a finder's fee of $100 for successfully recruiting new treatment parents.

o Presentations in the community to service clubs, YMCAs and YWCAs, rotaries, school PTAs, churches, and the like. Presentations may be about the program exclusively or may focus more broadly on such things as parenting skills or working with adolescents.

o Presentations and tours of the program for key individuals in the community such as ministers of large churches or community leaders who may be in a position to identify interested persons.

o Exhibits at malls or county fairs, particularly in West Virginia. At booths, the program might give away balloons with the program name and address, sponsor coloring contests, offer video pictures of children, or employ other attention-getting strategies.

- Media exposure through radio, television, and newspapers. Advertisements may be used as well as articles, appearances on talk shows, etc.

- Mailings to community and church leaders, local colleges and universities, and public schools etc.

Beyond using current treatment parents, community outreach and education are considered the most successful recruitment strategies, targeting key groups and individuals in the community.

The first step in the selection process allows interested couples to learn about PRYDE and to ask questions about the program and the youngsters served. If they are still interested, the couple then completes an application. The application form includes separate confidential, individual questionnaires for each spouse which ask pointed questions about their marriage, their strengths and weaknesses as a couple, and their strengths and weaknesses as parents. The questionnaires also include hypothetical situations involving children's troublesome behaviors which require the respondents to indicate what they might do.

The next phase is a lengthy and detailed interview conducted by at least two staff persons in order to yield two independent judgments about a couple. The interviewers complete ratings of the PRYDE parent applicants. If the ratings are positive, police and child abuse record checks are initiated and personal references obtained (on a reference form developed by PRYDE with specific questions). It is estimated that approximately 20 to 25 percent of the parents who inquire about PRYDE and about 60 percent of those who complete applications are accepted for training, which is seen as the ultimate screening process.

In addition, a home study must be completed in order for the treatment home to become a licensed foster home. PRYDE is licensed in Pennsylvania, West Virginia, and Maryland to conduct home studies and approve foster homes which expedites this process. Other programs must rely on the child welfare agency to conduct home studies and license homes, often with significant delays.

The PRYDE program requires treatment parents to complete an extensive preservice training program. Both treatment parents from each family are required to attend all 10 preservice training sessions, and parents are not paid for participating in training. The training is held over a six-week period, seven evening sessions and three Saturday morning sessions. Each class of parent trainees is taught by one professional staff person plus a certified PRYDE parent. Each PS/CL is required to attend one or more of the training sessions and to participate as either lead or secondary trainer.

The preservice training provided by PRYDE is skills-oriented and is designed to accomplish several important purposes:

- Teaching trainees to perform a set of skills which have been proven particularly effective in working with children who have special needs;

- Enhancing trainees' current parenting strengths;

- Screening out individuals who lack the time, energy, or commitment to complete all requirements of the training and the role of treatment parent satisfactorily; and

- Developing a cooperative, trusting relationship between program staff and trainees.

Manuals are provided for trainees, and the training is guided by a scripted trainer's manual. Training sessions typically consist of a lecture followed by discussion and workshop exercises in small groups. Reading and written homework assignments (included in the manuals) are required for each session. Videotaped vignettes are used to demonstrate the various treatment skills, and, at key junctures, the trainees are required to "test out" for particular skills to ensure that they have mastered them. Testing out is accomplished through the use of role plays in which staff act as youngsters and present parents with opportunities to use their newly learned skills. The 10 units included in the PRYDE preservice training are:

- Introduction to PRYDE and Foster Family-Based Treatment
- Behavioral Objectives: Motivating Through Social Rewards
- Behavior Management: Understanding Behavior and Relationships
- Motivation and Treatment Planning
- Communication - Active Listening
- Communication - I Feel Messages
- Skill Teaching/Making Friends
- Negotiation; Conflict Resolution
- Advocating for Youth in the Community; Avoiding Physical Confrontation; Passive Physical Restraint
- Stress Management; Graduation

Staff report that the training is difficult. The first session includes a large dose of the "fear factor" or the "dare factor" which involves forcefully facing the realities of working with emotionally disturbed children by presenting some of the "war stories" of current treatment parents. Although the trainer ends with wonderful, heart-warming stories, it is expected that as many as half the trainees will not return after the first training session. An active treatment parent related that the extensive requirements of the training program put a lot of pressure on trainees, but that they also give trainees a sense of how difficult it will be to work with the children. Most agree that it is better to drop out of the program during the training than subsequently when a child may be affected adversely. It is anticipated that about 50 to 60 percent of the families beginning preservice training will drop out or be screened out. At the time of the site visit, 14 families were in training.

The Intake Coordinator attends many of the training sessions to learn about new treatment parents. She obtains information about their preferences for particular ages or types of youngsters and observes their performance to assess their strengths and weaknesses. This assists the Intake Coordinator in the matching process. As training progresses, a case may be presented to treatment parent trainees if the youngster seems particularly appropriate for them. Even though preplacement visits can occur while the parents are still in training, the actual placement must wait until the treatment parents have successfully completed the preservice training and become certified. Graduation from preservice training, held during the last session, includes a party, a certificate, and a photo ID.

Inservice training also is provided for treatment parents. Nine substantive inservice training sessions are provided each year, with treatment parents required to attend a minimum of three according to state regulations. Two additional sessions are social events -- a Christmas party and summer picnic which include the children. Inservice training topics have included working with school systems, sexual abuse, children on medication, moral reasoning, and first aid. Inservice training sessions also give treatment parents time to share their own triumphs and troubles. Parents report that one of the most important aspects of these monthly meetings is the time spent with other PRYDE parents.

Advanced training in counseling skills and behavior analysis is available to highly qualified and experienced treatment parents. One of the advanced training seminars, called Behavior Analysis Training (BAT), meets one evening per week over an eight-week period. Parents must formally apply in order to participate in the advanced training program and are accepted based upon the level of their performance as treatment parents. The seminar is limited to four couples in order to allow the trainers to provide extensive, individualized consultation to participants related to each new skill. Advanced training in the areas of active listening and avoiding confrontations also is available to selected treatment parents.

In Pennsylvania and West Virginia, treatment parents are paid $22 to $28 per day per youth. In Maryland, per diem rates range from $31 to $36, and in the Intensive PRYDE program in West Virginia treatment parents are paid a per diem rate of $40. In all cases, rates can increase based upon the results of the treatment parents' performance evaluations. The per diem payment is intended to cover all expenses related to caring for a youngster including medical costs not covered by medical assistance, transportation, any vacations with the PRYDE family, any clothing beyond an initial clothing allowance, the youngster's allowance, and special events.

An extensive evaluation process is used to assess the performance of treatment parents regularly. Careful evaluation of treatment parents is seen as essential for ensuring that quality treatment is provided in the private homes where staff cannot provide continuous supervision. Parent evaluators are used to assess treatment parents' performance. The use of third parties, rather than relying solely on PS/CLs, enhances the objectivity of the periodic assessments. Evaluations are completed after the treatment parents' first 6 months of service, at 12 months, and subsequently on an annual basis.

The evaluation protocol spans five major areas: direct treatment and parenting; family environment; administration including completion of records and attendance at inservices; indirect treatment including advocating for the youth in school and assistance to natural parents; and youth performance. Data for rating the treatment parents in each of these major categories comes from a variety of sources including:

- Review of point sheets and LODEs,
- Questionnaire completed by the PS/CL who supervises the treatment parents, and
- Direct observation of parent performance of selected treatment skills.

The latter data source, direct observation of skills, is obtained by simulating situations in the home with the assistance of the PRYDE youngster. Through these simulations, treatment parents are given the opportunity to demonstrate the use of various treatment skills. Based upon all of this information, the parent evaluator rates the treatment parents in each of the five categories on a scale ranging from 0 to 4; an overall rating is derived by averaging the ratings in each sub-category. The overall rating earned on the evaluation determines the amount of pay increase for the treatment parents. Merit raises of $1 or $2 per day may be given based upon performance.

In addition, the evaluation results in a Professional Development Plan for each treatment family which includes specific recommendations for improving performance. Treatment parents who receive poor ratings on their evaluations may be placed on probationary status. If they fail to demonstrate the specified improvements within a period of time, they may be terminated from the program.

The average length of service for treatment parents is approximately two years, with a wide range of several months to more than eight years. Treatment parents leave the program for a variety of reasons. From 1982 to 1986, PRYDE trained 90 treatment families and during that time 28 percent left the program. Some treatment families moved out of the area (5 percent); some were terminated (10 percent); and still others "burned out." Clearly, burnout among treatment parents is a significant risk, and the program makes a concerted effort to support treatment parents in their jobs and to acknowledge their contributions and accomplishments. The strategies used include the following:

- Sending frequent letters with material about the program, training opportunities, etc.
- Publishing a newsletter for PRYDE parents which keeps them informed and serves as a team-building mechanism.
- Giving treatment parents a meaningful role in many aspects of the program's operation including preservice training, inservice training, program development, recruitment of new treatment parents, and assisting new treatment parents.
- Arranging for treatment parents to participate in dissemination efforts such as television or radio presentations, public presentations, and presentations at state and national conferences.
- Providing opportunities for treatment parents to be hired as staff when they become highly skilled and experienced.
- Recognizing treatment parents on a personal level by sending greeting cards on special occasions, sending special letters from the Director for a job particularly well done, and the like.
- Holding parties for parents and staff in order to strengthen treatment parent's identity with the program and to allow everyone to socialize in a relaxed context.

Another mechanism to support the vital role of treatment parents in the program is the Parent Advisory Board. The Board is comprised of six parents and provides a formalized structure for parents to offer constructive feedback and suggestions to guide the program. The Parent Advisory Board meets monthly and has made valuable contributions to the program in areas such as revising paper work, organizing clothing exchanges, planning inservice workshops, and publishing a newsletter.

In many situations, treatment parents also rely on each other for support. They contact each other by phone, often becoming like extended family. The relationships that develop among treatment parents are important aspects in maintaining both morale and cohesiveness.

Resources

The Fiscal Year 1987 budget for the PRYDE program was approximately $1.9 million. Pennsylvania PRYDE accounted for over $1.5 of that budget, with the West Virginia program budget at approximately $430,000. The Fiscal Year 1989 budget for the programs in all three states combined is $4.1 million.

The program is funded through purchase of service contracts. These contracts are with the county Children's and Youth Services agencies in Pennsylvania; 10 counties including Allegheny County have contracts with PRYDE. Through these contracts, the county reimburses PRYDE for the per diem cost of therapeutic foster care with 75 percent state dollars and 25 percent local dollars. An incentive to use community-based services such as therapeutic foster care is found in the Pennsylvania requirement that counties pick up a 50 percent share of residential treatment costs, as opposed to the 25 percent share they pay for therapeutic foster care. In West Virginia, the purchase of services contract is with the state Department of Human Services. In Maryland, separate contacts are in force with the state of Maryland and Baltimore City. Both of these contracts started as fixed price program funding to support the initial period of program development; both contracts currently are shifting to a per diem funding mechanism similar to those in PRYDE's other sites. These are the sole funding sources for PRYDE; no fees are charged for PRYDE's services and the program does not receive third party reimbursements of any kind.

PRYDE charges a per diem rate based upon the average cost per day of providing services. The per diem rates are calculated by dividing the total cost of operating the program by the average number of days of service for the year. This formula yields the per diem cost for the succeeding year. A problem for the program occurs when funding agencies are unwilling or unable to pay the full per diem cost of providing services. An annual process used to renegotiate per diem rates with each funding agency often results in a struggle to recoup the full cost of services. For example, while the Fiscal Year 1987 per diem cost of services in West Virginia was calculated at $50.41, the state would not exceed a $48 cap on the per diem rates for therapeutic foster care. Similarly, Allegheny County had frozen its per diem rates at $48.89 for Fiscal Years 1985 and 1986. For Fiscal Year 1987, Allegheny County negotiated a per diem rate which was still less than the actual cost of services -- $51.12 when costs were calculated at $52.36.

For Fiscal Year 1990, PRYDE's per diem rate in Pennsylvania is $58.64, $56.71 in West Virginia, and $76.09 in Maryland. The state of West Virginia has removed its previous per diem cap, but continues to reimburse the program at a rate lower than the cost of care. The rate for the Intensive PRYDE program in West Virginia is $163.44 per day and is approved only on a client-by-client basis.

PRYDE's funding is considered stable, but inadequate. The problems with funding are attributed to the reluctance of funding agencies to reimburse for the full cost of service provision, even though youngsters served are at risk for entering far more expensive treatment settings. Regardless of the low per diem reimbursements, the program generally breaks even. This is accomplished by serving additional children beyond the average census figure used to calculate the per diem cost of services.

Evaluation

The major outcome index used to measure PRYDE's effectiveness is the concept of "successful discharge," defined as moving to a less restrictive setting than PRYDE. Less restrictive settings include home, regular foster care, adoption, or emancipation. Of all the youngsters served since the program's inception in 1981, approximately 75 percent were successfully discharged to less restrictive settings.

In addition to looking at discharge data, each summer the program attempts to obtain follow-up information on children discharged from PRYDE one to two years earlier. The follow-up interview, conducted by phone, checks on youngsters' current placement status to see if they are still in less restrictive settings. Surprisingly little deterioration is found over time. The 1986 follow-up project collected information on 44 youngsters who had been discharged from PRYDE over a two-year period from 1983 to 1985. Findings revealed that 73 percent of the children were still living in less restrictive settings. Smaller samples studied during the summers of 1987 and 1988 found 82 percent and 69 percent respectively of the youngsters still in less restrictive living situations.

The follow-up projects also involve gathering information about productive activity and problems displayed during the follow-up period. The 1986 study found that 54 percent of the youths had either earned a secondary school diploma or GED or were in a less restrictive school setting, and 73 percent were either attending school or were gainfully employed. Relatively small percentages of the youngsters had known incidents of antisocial behavior or police contact. Alcohol problems were documented for 9 percent of the youths, stealing for 14 percent, aggression for 9 percent, drugs for 12 percent, and police contact for 23 percent. Seventy-one percent of the youths had none of the above problems.

An evaluation of client satisfaction also is an integral part of PRYDE's evaluation efforts. A Youth Satisfaction Questionnaire or youth interviews are completed on an annual basis as part of the PRYDE evaluation process. PRYDE parent satisfaction evaluations also are conducted regularly. Results have generally indicated that youngsters and treatment parents are pleased with the program. The children report that they like their treatment families and often do not like the point systems, although they think that the expectations are fair and that the treatment families are helping them. Treatment parents report general satisfaction with program supports and eagerness to have reduced staff turnover so that they can continue working with the same PS/CL over time. A recent PRYDE Pittsburgh survey of treatment parents revealed that parents were attracted to the program and remained because of the training and support services provided.

In addition to these evaluation activities, the program received a grant from the Buhl Foundation to support research comparing PRYDE to several other treatment alternatives. The sample for this comparative evaluation consisted of 461 youngsters who were all referred and accepted by PRYDE, but 75 percent of whom were ultimately admitted elsewhere due to the lack of availability of treatment homes. The study sample was comprised of 26 percent of these youths served by PRYDE as compared with groups of youngsters served by residential treatment centers, specialized foster care programs, group homes, intensive treatment units, and a group returned home to family or friends. The groups served by these various program types were found to be generally comparable, and preliminary evidence suggests that the PRYDE group was comprised of particularly difficult cases.

The first aspect of this study involved constructing a restrictiveness scale in order to quantify the restrictiveness of various treatment settings. The youngsters in each setting were then compared according to the restrictiveness, duration, and cost of further placements following discharge from the initial or target placement. The study found that, on average, PRYDE discharged youngsters to less restrictive placements than other target programs, significantly less restrictive than the discharge placements of youngsters in residential treatment centers and intensive treatment units. PRYDE discharged the most children (61 percent) to family and independent living situations and had the most children remaining in such situations one year later. The researchers speculated that if a program's treatment setting is within the context of a family and community, youngsters may learn to function in these environments and may be more likely to remain there. Further, PRYDE youth spent the least amount of time in out-of-home placements following discharge from the target placement.

The preliminary results of this comparative evaluation suggest that PRYDE is a "viable and effective alternative for some of the children placed in more restrictive placements." The researchers concluded that if more PRYDE families were available, many of the children referred to the program but placed in group facilities could have been successfully served in less restrictive family settings.

Major Strengths and Problems

Program administrators, staff, professionals from other agencies, PRYDE parents, and natural parents cited the factors that they feel make PRYDE successful. The major strengths identified through this process include the following:

o Skill of PRYDE parents and their commitment to their work with troubled children.

- High quality, expertise, and creativity of staff coupled with their warmth, responsiveness, and helpfulness.

- Twenty-four hour availability of crisis intervention and availability of staff at all times.

- Flexibility to adapt the program to meet the needs of individual children and to do whatever is necessary to support the placement.

- Extensive and excellent skill-based training for treatment parents and staff.

- An approach with natural parents which helps them feel comfortable and supported rather than accused or blamed.

- Strong support and back-up from the agency.

- High levels of accountability in every aspect of the program.

In addition to these strengths, a number of problem areas were noted. One of the ongoing struggles is to get other agencies and professionals to recognize that severely disturbed children can be served effectively with therapeutic foster care. Many professionals, particularly mental health professionals, do not recognize the qualitative difference between regular and therapeutic foster care and tend to recommend treatment in more traditional settings. An ongoing effort is needed to educate community agencies and professionals about the potential of therapeutic foster care and the value of PRYDE.

Another problem, and one which is increasing, relates to abuse allegations brought by youngsters against treatment parents. The program handles these situations by removing the child from the treatment home and conducting an investigation in conjunction with the Children's and Youth Services Agency. Out of approximately 40 such allegations in 1989, all but two were determined to be unfounded allegations. PRYDE attempts to prepare treatment parents for the possibility of such allegations. During preservice and inservice training sessions, PRYDE parents are warned that this may occur and are informed about the nature of abuse investigations. While an attempt is made to expedite these investigations, this is not always possible. They often take time and create tremendous vulnerability and stress for treatment parents. PRYDE administrators stated that, due to increasing allegations of abuse (most of which are false), the program is considering making appropriate liability and legal assistance available to treatment parents.

Other problems include:

- Ongoing struggle to recruit treatment parents.

- Lack of availability of appropriate school placements and special education services. (Many areas do not have specialized programs available for seriously emotionally disturbed children, and some are resistant toward serving these children.)

- Excessive length of time from referral to placement. (The program often is bombarded with referrals, creating an extensive waiting list and an inability to serve many children due to the limited availability of treatment homes.)

- Difficulty in recruiting and retaining qualified staff who are willing to cope with the stressful and difficult working conditions and nontraditional hours required by the PS/CL job.

- Compensation which does not always cover all expenses for treatment parents. (For example, treatment parents report that they often assume the expense for back-to-school clothes and other items for youngsters.)

Dissemination

The PRYDE program is heavily involved in activities to promote therapeutic foster care in general and the PRYDE model in particular. Program administrators and staff see it as a challenge to replicate the PRYDE model in other areas and environments, an attitude that has led to the PRYDE programs in West Virginia and Maryland. When starting a new program, PRYDE attempts to spin off a group of experienced staff members to spearhead the program development process. While new programs have been started with only one experienced staff person, this approach results in an entire, newly recruited professional staff that lacks familiarity with the therapeutic foster care concept and approach. It is considered ideal to have two or more current staff go to a new area as a team to start a new program. Program managers emphasize the necessity of modifying the program and its procedures in order to accommodate the needs and culture of a different area.

PRYDE leaders and staff also have been involved in numerous national efforts to promote the development of therapeutic foster care. The PRYDE Director and staff attended early conferences sponsored by the NIMH Division of Violent and Antisocial Behavior which brought together people involved in therapeutic foster care. PRYDE was involved in planning and, in some cases, co-sponsoring subsequent meetings on therapeutic foster care, including the first several North American conferences on therapeutic foster care.

The overall PRYDE Director has been instrumental in the formation of the fledgling organization for the advancement of therapeutic foster care, the Foster Family-Based Treatment Association (FFTA) and serves on its Board of Directors as well as on its Executive Committee. In addition, the PRYDE Director and another staff person recently served as co-editors of a book on therapeutic foster care (Troubled Youth in Treatment Homes: A Handbook of Therapeutic Foster Care, edited by P. Meadowcroft and B. Trout) which was published in 1989 by the Child Welfare League of America. Contributions to the book, which offer practical assistance on developing and operating programs, were provided by a number of PRYDE staff members in their particular areas of expertise -- parent recruitment and training, serving natural parents, program evaluation, and so forth.

PRYDE offers extensive consultation to assist developing therapeutic foster care programs. Program developers have come to the PRYDE program for two-day consultations. The program may have such guests as often as every other month. In one case, a week-long consultation/training at PRYDE was provided for the director of a new therapeutic foster care program. In addition, consultation has been provided to state agencies to assist in program development efforts. In Kentucky, for example, PRYDE trained an initial group of treatment parents and staff during two weekend sessions with three day-long follow-up sessions. The training was videotaped to allow for future use. The types of consultation services available from PRYDE include:

- Training on model development at the PRYDE central office.

- Consultation at the program developers' site.

- Complete preservice parent training classes including manuals and all materials.

- Training of staff to provide the PRYDE preservice training to treatment parents.

o Other technical assistance such as staff training.

Case Examples

A 16 year-old-white female ("A") was referred to the West Virginia PRYDE program. A's presenting problems included a range of behaviors including sexual promiscuity, running away, physical aggression, and frequent "seizures" with no apparent physical cause after extensive testing. Seizures, which on occasion occurred as often as six times a day, involved a variety of behaviors including rapid jerking of the body, math recital, sequential straightening and bending of the limbs, clothing removal, fumbling with curtains, and feeling around walls. Additionally, A alleged that she had been sexually assaulted on numerous occasions, although none of her allegations were substantiated. A's natural parents' rights were terminated, however, her natural mother was supportive of the PRYDE program and was actively involved. Two siblings remained at home with the natural mother. A was placed in a treatment home in a rural area which presented less opportunity to run away or to prostitute. The PRYDE family had two other PRYDE youngsters in placement as well as two natural children. The PRYDE parents were well educated and religious individuals who were self-sufficient. Placement in a private school was arranged for A in order to contain and respond to her seizure activity. The other children in the home were taught how to respond to possible sexual advances or physical aggression.

The treatment goals established for A included: stays where assigned; follows directions; refrains from having pseudo-seizures; interacts appropriately with others; solves problems in an appropriate manner; and speaks positively about herself. A weekly log of target behaviors was used in lieu of a motivation system. Treatment in the PRYDE home resulted in a number of significant achievements for A. Opportunities to allege sexual assault were prevented and there were no further allegations. Responses to seizure behavior were consistent at home and at school and resulted in reduced seizure activity. Incidents of physical aggression and sexual misconduct were reduced markedly. Eventually, after two and a half years in PRYDE, A was successfully discharged to the home of a neighbor of her mother's in her home community. When last contacted, A was employed part-time and was considering marriage.

An 11-year-old female ("T") was referred to PRYDE in Pittsburgh. She had been removed from her family along with two other siblings as a result of severe neglect, and, prior to her referral to PRYDE, spent three years in a child care institution. Her presenting problems included, among others, inappropriate sexual behavior (public masturbation), bed wetting, aggressive acting out, poor social skills, poor attention span, and inability to complete a task or conversation. The goal upon entering PRYDE was eventual reunification with her natural parents.

The Ritalin that T was on while in the child care institution was discontinued at PRYDE, and a motivation system was implemented both in the PRYDE home and at school. The initial focus was on T's attention deficit disorder, and the PRYDE parents proceeded to work intensively with T, teaching her appropriate behaviors and a variety of skills. The PRYDE parents spent nearly two hours with T each evening tutoring her and working on her homework.

In addition to providing treatment to T within the PRYDE home, the program worked extensively with T's natural parents. The parents were very interested in getting T back, and regularly attended the natural parents' group. Individualized training also was provided to the parents to teach them needed parenting skills and survival skills including budgeting and others. Counseling was provided to the natural parents as well, and the father was linked with Alcoholics Anonymous to deal with his alcohol problem. The natural parents practiced and kept track of their parenting skills with a son who remained in the home and with T on her home visits every other weekend. Assistance to the natural parents also was given in finding a larger apartment.

T currently is still placed in the treatment home where she has been for three years. T's parents ultimately divorced. Her mother is working full-time and supporting the family. Ongoing training and assistance has continued for the natural mother; the father has refused any additional support and has not complied with a court order to attend Alcoholics Anonymous. T's mother has continued to attend the natural parents' group. T has made much progress in her treatment home and at school, and vast strides have been made by her natural mother. The discharge plan for T involves an extensive array of supports to assist in the reunification with her mother and in providing ongoing support to the family. The range of supports considered include a special tutor for T, structured recreational activities (Girl Scouts or Big Sister Program), homemaker services to assist the family, continued attendance in the natural parents' group, and possible ongoing monitoring and supervision from the PS/CL.

A 16-year-old male ("C") was referred to the Pittsburgh PRYDE program in 1986. C's stepmother requested his placement because his father had left town due to his job, and she was not able to manage C on her own. C's history included physical abuse and neglect by his natural mother, step-mother, and natural father who is an alcoholic. He had been in and out of group homes for some time and came to PRYDE with presenting problems including stealing, anxiety, lying, severe depression, feelings of inadequacy, and inappropriate sexual behavior with children. The goal upon entering PRYDE was independent living.

The PRYDE program attempted to work with C's natural parents. His father discontinued all contact or involvement with the program approximately one year after C's placement, and his mother made no attempt to contact PRYDE or attend scheduled meetings. C, however, made great strides in his PRYDE home. He attended and graduated (in 1988) from the Pressley Ridge Day School. Because of his intellectual deficits, his lack of biological family resources, and his need for close supervision as a result of his inappropriate behavior with children, C agreed to remain in his PRYDE home beyond his emancipation age. There he continued to work on his treatment needs in a supervised, supportive environment. C worked on independent living skills and life skills while in the PRYDE home in addition to behavior deficits. Additionally, he completed a vocational/technical program.

C was emancipated in 1989 and currently is living in an independent living program for young adults that offers support services. He is employed part time and is actively involved in a bowling league as well as in other activities. C's PRYDE parents and PS/CL continue to maintain a relationship with C and with his counselor in the independent living program.

Technical Assistance Resources

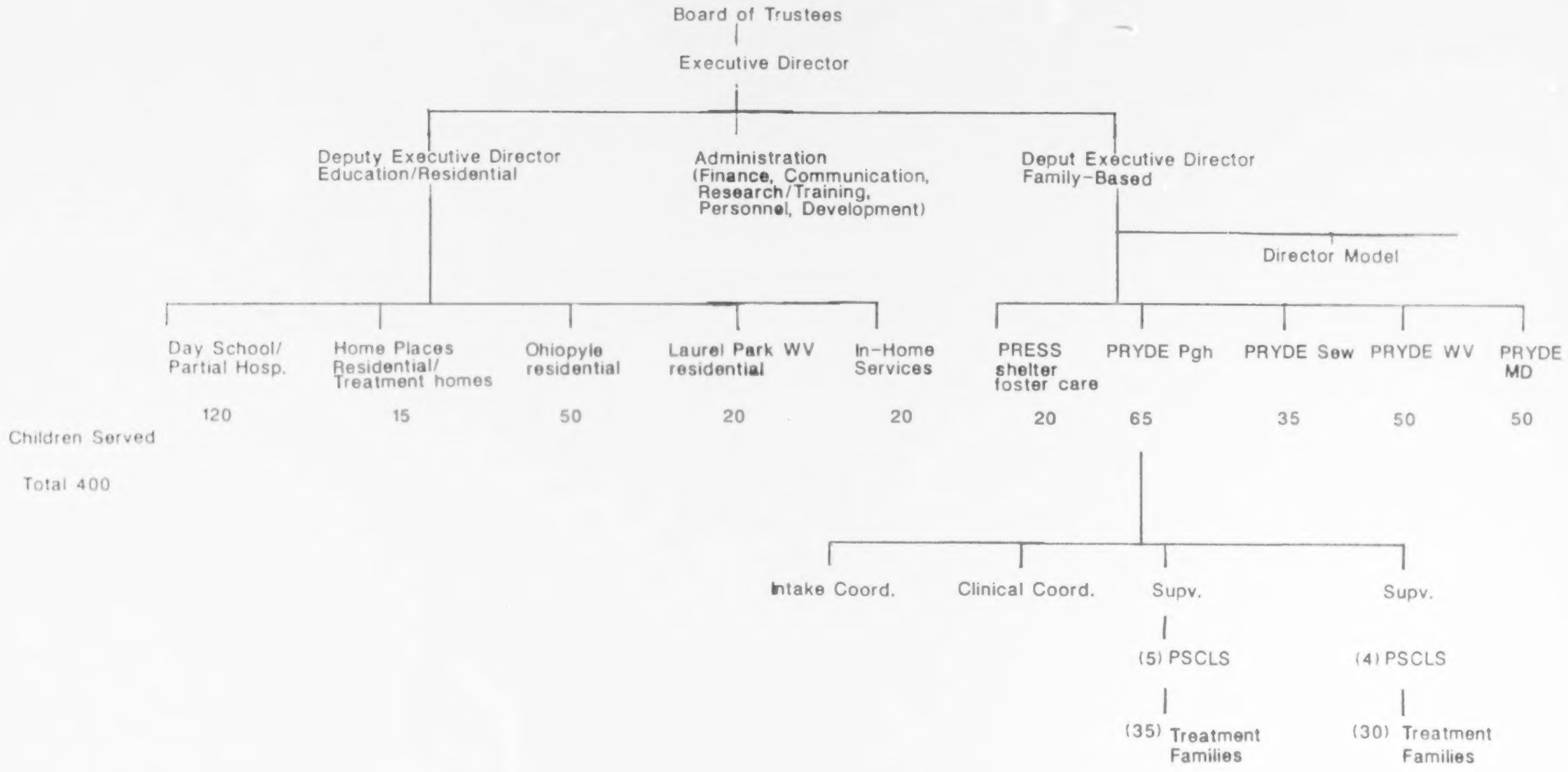
PRYDE Parent Training - Trainees' Manual
PRYDE Parent Preservice Training - Trainers' Manual
PRYDE Parent Supervisor/Community Liaison Manual
PRYDE Natural Parent Services Manual
PRYDE Parent Policy Manual

PRYDE Youth Interview (Introductory)
Interview Questions for Potential PRYDE Parents
Purchase of Service Agreement between the County of Allegheny and the Pressley Ridge School

Program Forms:

Information to PRYDE Parents About Youth
Notice of Placement to School
Notice to Natural Parents
Natural Parents' Consent Form
Child Descriptors at Entry Form
Daily Merit Sheet
Merit Sheet
PRYDE Mastery Behaviors
Daily School Report
PRYDE Point Sheet
PRYDE Log of Daily Events
PRYDE Youth Performance Summary
Use of Daily Treatment Skills Summary
Discharge Status
Morning Report Events
Incident Report
Discharge Status
PRYDE Youth Evaluation Form

The Pressley Ridge Schools


Board of Trustees
Executive Director
Deputy Executive Director Education/Residential
Administration (Finance, Communication, Research/Training, Personnel, Development)
Deput Executive Director Family-Based
Director Model
Day School/ Partial Hosp.
Home Places Residential/ Treatment homes
Ohiopyle residential
Laurel Park WV residential
In-Home Services
PRESS shelter foster care
PRYDE Pgh
PRYDE Sew
PRYDE WV
PRYDE MD
120
15
50
20
20
20
65
35
50
50
Children Served
Total 400
Intake Coord.
Clinical Coord.
Supv.
Supv.
(5) PSCLS
(4) PSCLS
(35) Treatment Families
(30) Treatment Families

PRYDE FAMILY-BASED TREATMENT PLAN

Client: 13 year old boy with extensive history of out-of-home placements in educational and residential treatment facilities. Prior placements were considered unsuccessful due to impulsive and aggressive behavior, running away, delinquent behavior, truancy, global and peer social skill deficits, unsatisfactory responsiveness to attempts by others to motivate him, noncompliance to adult instructions, an extremely low tolerance for frustration, and high levels of anxiety and restlessness.

Targeted Treatment Behaviors

1. Reduce verbal aggression toward peers and adults.

2. Eliminate physical aggression toward peers and adults.

3. Increase impulse control and appropriate problem-solving skills.

4. Increase adaptive anger management skills.

5. Eliminate fire-setting behavior.

6. Increase academic abilities and skills.

   a. Remediate and maintain academic performance at grade level.
   b. Increase attending and "on task" behaviors.
   c. Decrease disruptive and learning incompatible behaviors.

7. Increase compliance to adult instructions.

8. Increase age-appropriate recreational and socialization skills.

9. Eliminate stealing behavior.

10. Increase adaptive daily functioning within family and community-based settings.

11. Demonstrate vocational interests and specific career skills.

12. Abstain from all substance abuse.

13. Replace any age-inappropriate sexual behavior with socially acceptable behavior.

PRYLE MOTIVATION SYSTEM

NAME: ____________________

DAY: ____________________

DATE: ____________________

Allowance
Earned
Today:

Point Summary for Today
Pts. Earned: __________
Pts. Lost: __________
Points: __________
LEVEL 1 2 3

	BEHAVIOR	criterion for merit move	current status	POSSIBLE PTS.		EARNED PTS.	
				+	-	+	-
T1	Uses appropriate language and tone.			100	100		
T2	Responds non-aggressively to others.			100	R/L		
T3	Expresses emotions approp.			200	300		
T4	Follows directions approp.			100	100		
T5	Informs supervising adult of any changes in whereabouts.	Max. 3		100	200		
T6	Tells the truth.			100	200		
T7	Stays where assigned.			100	250		
T8	Accepts and participates in skill teaching.			200	200		
T9	Has permission to use others property.			200	300		
T10	Does homework at agreed upon times.			150	200		
T11	Completes school assignments correctly.	100 for each -500 for < 100%		100	500		
T12	Expresses only appropriate humor.		Max. 3	50	100		
T13	Displays good social skills with others.		Max. 2	100	150		
SE1	Expresses feelings in timely manner.			200	200		
M1	Participates in point sheet.			100	100		
M2	Maintains good hygiene.			100	100		
M3	Cleans up after self.			100	100		
M4	Does assigned chores.			100	100		
M5	Keeps room neat & clean.			100	100		
			TOTAL THIS PAGE				

POINT REQUIREMENTS

LEVEL 1 Below 60%

LEVEL 2 60% - 79%

LEVEL 3 80% - ++

EXTRA POINTS:

Total = pts. earned + pts. lost. Then:
pts. earned - total pts.

BONUS:
¢.40 for each 5% over 80%

Page 2 total	
Page 3 total	
Negotiated pts	
TOTALS	

PRYDE POINT SHEET

Name: S
Rev: 01/89
Day:
Date:

Allowance
Earned today

Point summary for today
Pts earned:
Pts lost:
Net Points:
Level for ______ 1 2 3

Code	Behavior	Possible Points		Earned Points	
		+	−	+	−
T1	Refrains from contact, interaction with children (under 15) without supervision	Auto. Level 1	-----		
T2	Interacts appropriately with children (under 15) (2)	20 ea.	40 ea.		
T3	Interacts responsibly and makes appropriate, positive pleasant, helpful statements, comments, suggestions, gestures and faces when addressing Carl. (3)	20	40		
T4	Refrains from sexually inappropriate and socially unacceptable behavior such as: peeping, snooping, evesdropping, touching others personal and/or private belongings, clipping pictures & other inappro. materials	20 ea.	30 ea.		
T5	Follows instructions and house rules consistently, appropriately and/or promptly (2)	20 ea.	30 ea.		
T6	Accepts counseling, instruction, skill teaching and feedback (3)	20 ea.	30 ea.		
T7	Reports facts completely and immediately	20	20		
	Reports facts completely and delayed (2)	10	30		
	Reports facts incompletely and delayed	0	40		
T8	Maintains appropriate behavior when upset Refrains from punching things and other hurtful or self destructive behavior (2)	20 ea.	30 ea.		
T9	Asks permission to borrow items Returns items to proper place promptly (2)	10 ea.	20 ea.		
T10	Acknowledges people when spoken to Faces person when talking and listening (3) Maintains eye contact	5 ea.	10 ea.		
T11	Initiates conversations Provides appropriate responses (3)	5	10		
T12	Initiates problem solving and negotiation -put forth best effort (3) -ask questions as needed -initiate skill teaching	10 ea.	20 ea.		
T13	Expresses feelings appropriately with I feel or I need messages	10 ea	20 ea		
	Total points this page				

Point Requirements
Level 1 = 0 - 220
Level 2 = 221 - 295
Level 3 = 296+

Page 2 Total :______:

Bonds:

Total :______:

Code	Behavior	Possible Points		Earned Points	
		+	−	+	−
T14	Writes in journal	5	5		
M1	Avoids stealing	Auto. Level 1	-----		
M2	Completes homework when given and makes corrections	10 day	20 day		
M3	Maintains grooming: takes shower daily shampoos, brushes and flosses twice daily takes vitamin	10 day	20 day		
M4	Picks up after self/items where they belong (good room upkeep, dirty clothes in hamper, hang clothes, put up possessions)	10 day	20 day		
I1	Completes an extra chore	5 ea	-----		
I2	Watches educational T.V.	5 day	-----		
I3	Participates in family activities/organized activities	5 day	-----		
	Total points this page				

Point Requirements
Level 1 = 0 - 220
Level 2 = 221 - 295
Level 3 = 296+

Page 2 Total ________

Bonds: Total ________

House Rules:

1. Abide by supervision restrictions
2. NO smoking, drinking, drugs
3. NO stealing
3. Obey curfew - set per outing
4. Ask permission to use phone
5. Privileges and allowance to be earned through point sheet

PRYDE LOG OF DAILY EVENTS (LODE)

Person completing LODE: ____________________

Youth: ____________________

Day of week and date: ____________________

1. Finish your LODE as close to the end of the day as possible
2. Report treatment activities of PTP and STP as completely as possible
3. Fill in all blanks and report who used each skill (Sections A & B).
4. Highlight treatment issues.
5. **REMEMBER: Your LODE is PRYDE's official record of youth treatment.**

A. PARENTING SKILLS

PTP STP 1. I used a social reward in the following instance. Youth behavior I rewarded: ____________________

What I did and/or said: ____________________

PTP STP 2. I told another person about an achievement or positive accomplishment by the youth. Whom I told: ____________________

What I told about: ____________________ Told it in front of the youth? Yes NO

PTP STP 3. I used an idea or suggestion made by my PRYDE child. ____________________

PTP STP 4. I used active listening when the youth displayed or expressed the following emotion or feeling: ____________________

Situation which caused the feeling: ____________________

PTP STP 5. I used an I message in the following situation: ____________________

What I said: ____________________

PTP STP 6a. I used the following skill-teaching components to teach the youth the following behavior: ____________________

____ Previously taught skill ____ New skill

- ___ affectionate opening statement
- ___ social reward or I-message
- ___ why youth behavior was inappropriate (replacement beh.)
- ___ verbal description of skill
- ___ demonstration of skill
- ___ youth practice of skill
- ___ explain short & long-term consequences of behavior

6b I helped generalization by teaching the above behavior in a new setting or with new people. New setting: ____________________

New people (circle): PTP STP PSCL my own child teacher neighbor Other ___

PTP STP 7. I reached a cooperative decision or resolved a conflict by using these negotiation components on the following issue.

Issue: ____________________

(If you used more than 4 components, attach a description which includes the decision.)

- ___ positive start
- ___ define problem
- ___ Follow-up
- ___ generate solutions
- ___ evaluate alternatives
- ___ decide best solution
- ___ plan implementation

Who suggested the chosen solution? ____________________

B. DISCIPLINE: In addition to points or in a situation where points didn't apply, I used:

PTP STP Positive procedure: reinforced a positive opposite behavior, contracting, other: ____________________

Youth behavior: ____________________

Worthiness of behavior:

awesome awfully good appropriate

PTP STP Negative procedure: extinction, time out, response cost, restitution, other: ____________________

Youth behavior: ____________________

Severity of youth behavior: serious medium mild

C. RATING OF THE DAY: Rate your feelings or attitude toward the youth for this day only. Then indicate in your narrative what events influenced your rating.

	ecstatic		satisfied		disappointed		no interaction
PTP	6	5	4	3	2	1	NI
STP	6	5	4	3	2	1	NI
		pleased		so-so		disgusted	

Circle one: A. Consistent day: rating fits for most of the day

B. Inconsistent day: rating reflects overall attitude toward youth at day's end, though day has been variable

BEST COPY AVAILABLE

D. NATURAL FAMILIES:

Check if your youth had the following today: ___ Home Visit ___ Phone Call ___ Letter ___ Other (what?)

What member of natural family? ______________ Conduct was ___ positive ___ negative Comment in "observations" if negative

---

E. ACTIVITIES

For each period of the day record the youth's activities. Be brief and specific. For each activity record the amount of time and the people involved, as well as whether or not you consider the influence of others involved to be prosocial. Finally, circle one of the "Class of Behavior" codes for each behavior (key to codes follows).

OP — Out of home. Parent organized and run OC — Out of home. Community Involvement. YMCA, school activities, team sports, church activities, etc.
OU — Out of home. Unorganized, visiting, hanging out, movies (no parent), playing with friends, etc.
IA — In home Active, phone talk, chores, games, reading, etc. IP — In home Passive. TV, radio, napping, etc.

	Activity	Amount Time	With Whom?	Pro Social?		Class of Behavior				
MORNING										
1	______	______	______	Y	N	OP	OC	OU	IA	IP
2	______	______	______	Y	N	OP	OC	OU	IA	IP
3	______	______	______	Y	N	OP	OC	OU	IA	IP
AFTERNOON										
1	______	______	______	Y	N	OP	OC	OU	IA	IP
2	______	______	______	Y	N	OP	OC	OU	IA	IP
3	______	______	______	Y	N	OP	OC	OU	IA	IP
EVENING										
1	______	______	______	Y	N	OP	OC	OU	IA	IP
2	______	______	______	Y	N	OP	OC	OU	IA	IP
3	______	______	______	Y	N	OP	OC	OU	IA	IP

F. YOUR OBSERVATIONS

Author's Initials: ________

1.) Describe important events as specifically as possible. 2.) Focus on treatment behaviors and possible new ones. 3.) Include positive as well as negative youth behaviors. 4.) When describing a youth behavior include events preceding the behavior and the reactions or consequences the behavior produced. 5.) Describe the topics of any significant conversations. Note who initiated the conversation and its approximate length.

PRYDE Professional Treatment Parents

A profile

Professional treatment parents are people in your community whose speciality is caring about kids. Some are college graduates, but a degree is not required in this profession. Some have children of their own; others have no children but believe they have good parenting skills. And some of our treatment parents have raised their own families and are grandparents.

Our treatment parents come from all walks of life. They are teachers, principals, construction workers, business people, nurses and homemakers. They are diverse, but they share a common goal. All have a commitment to improving the lives of children and teens.

You can be a treatment parent

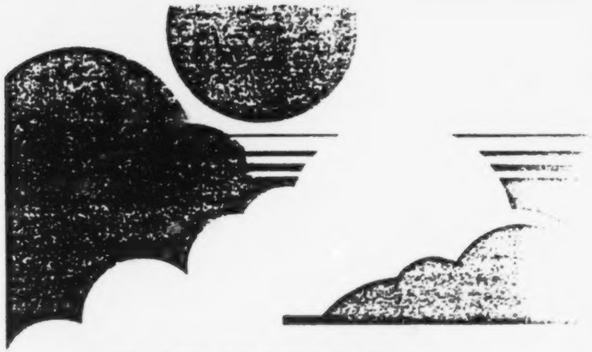
With the intensive training that **PRYDE** provides, you can become a professional treatment parent for a troubled child. You don't need a degree in counseling or teaching. **PRYDE** provides the training and ongoing support you need to do the job. What you need is the ambition to learn, the willingness to open your home and your heart to a troubled youngster and the desire to make a difference in the life of a child.

Treatment parents are people who want to make a profession out of caring for kids.

Pressley Ridge

Foster family based treatment for children and youth

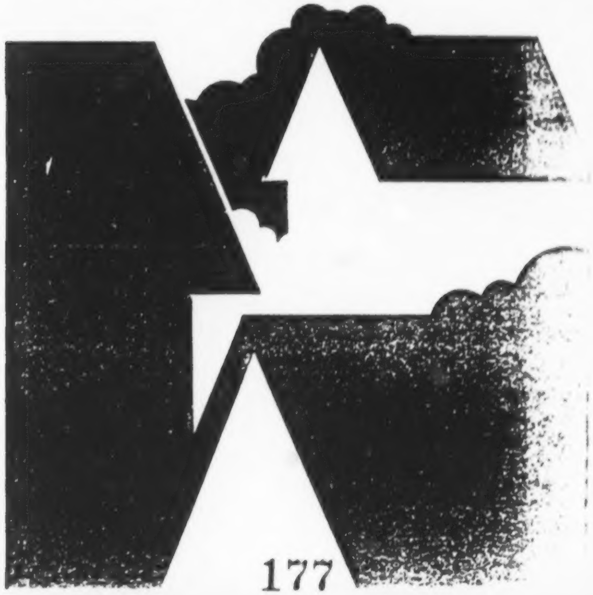
PRYDE Pittsburgh
530 Marshall Avenue
Pittsburgh, PA 15214



PRYDE

Professional Treatment Parenting

A Profession for You
A Home for a Special Child



PRYDE Youngsters

A profile

Youngsters in our **PRYDE** program have been removed from the custody of their parents because of family problems and because of the child's own behavioral and emotional problems. These are children and teens who cannot be placed in traditional foster care homes because they need professional treatment and counseling. But they also need to be part of a family. Filled with fear, anger or frustration and unable to deal with their problems, all have difficulty developing positive relationships with peers or adults. Many are reacting to the abuse and neglect they've experienced in their lives. Some may have special medical problems or be pregnant teens. They are youngsters with potential, but they are at risk to fail if they do not receive the help they need.

***PRYDE** youngsters are kids who need a home and professional parents to care about them.*

PRYDE

A home and an opportunity for a troubled child

In our **PRYDE** homes troubled youngsters receive the basics — food, clothing and shelter. But more importantly, they experience, perhaps for the first time in their lives, stability, security and positive discipline. They learn how to be part of a normal family, how to be successful in school and how to be a responsible member of a community.

Working together, our **PRYDE** staff and parents are giving children and teens hope for a brighter future. To return home successfully or to become independent, well-adjusted young adults remains the goal of all **PRYDE** youths.

PRYDE works! For the hundreds of children who have been in the program, **PRYDE** has made a difference and will continue to do so for many more.

But **PRYDE** also turns away over 200 children each year, most of whom will probably be placed in institutions.

You can help us help a waiting child. As **PRYDE** grows, fewer children will have to be turned away.

If you

- are over 21 years of age and are in good health
- believe you have good parenting skills
- want to take advantage of free professional training
- want a job you can do at home
- could use $8,000 to $9,800 in added tax-free income
- care about troubled children
- have room in your heart and home . . .

Join our team to care for kid

For more information contact us today at our **PRYDE** office nearest you.

PRYDE

In the greater Pittsburgh area:
(412) 321-6995
530 Marshall Avenue
Pittsburgh, PA 15214

In the Sewickley/Beaver County areas:
(412) 741-1310
801 Beaver Street
Sewickley, PA 15143

***PRYDE** is a program of The Pressley Ridge Schools, a nonprofit agency serving children and families since 1832 with central administration office in Pittsburgh, Pennsylvania. It provides services without regard to race, color, religious creed, ancestry, sex, handicap, age or national origin.*

IV. PROFILES OF THERAPEUTIC FOSTER CARE PROGRAMS

The first phase of this study of community-based services for children and adolescents who are severely emotionally disturbed involved identifying existing programs. A range of programs providing home-based services, crisis services, and therapeutic foster care were identified by key informants during the initial phase. A questionnaire was then sent to each identified program in order to gather detailed information about the program's characteristics. The information from these questionnaires was summarized in the form of a one-page profile of each program in order to provide specific examples of a variety of programs.

The profiles contain the following information about each program:

- Type of Community - urban, suburban, rural, or mixed.
- Type of Agency - agency type and whether public, private nonprofit or private-for-profit.
- Capacity/Staffing - number of children or families served at a given time and number of full-time equivalent (FTE) staff.
- Age Range - range in age of children served.
- Majority Age - age categories of majority of children served.
- Sex - percent of males and females served.
- Race - racial characteristics of children served.
- Diagnosis/Reasons For Not Accepting - percent of children served with various diagnoses and reasons for which children would be considered ineligible or inappropriate for services.
- Duration/Intensity - length of the intervention in weeks, months, or years and number of hours per week spent with the child and family.
- Description - brief description of the program and the services provided.
- Observations - funding sources, other services provided by the agency, interesting aspects of the program, availability of evaluation data, noteworthy evaluation results, linkages with other agencies, whether case management is provided, advocacy activities.

It should be noted that programs were asked to use readily available data to complete the questionnaire so as to minimize response time as well as response burden. Programs without data were asked to provide estimates for purposes of these profiles. Therefore, the data contained in the profiles should be considered estimates. Further, information in some categories (such as diagnoses) may be collected and used differently by each individual program. Thus, certain categories of information are not directly comparable across programs. Additionally, it should be noted that this data was collected from 1986 to 1988. Since programs and the populations they serve are frequently refined and adapted to current needs, some program characteristics may have changed appreciably since the preparation of the profiles.

These profiles are not intended to represent the universe of therapeutic foster care programs. There are, of course, many more programs in existence. These profiles are intended as examples of a variety of programs to assist states and communities in their program design and development efforts. The program profiles are presented in alphabetical order.

APPALACHIAN MENTAL HEALTH CENTER, FAMILY SERVICES NETWORK
Beverly, West Virginia
Reg. III
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Private nonprofit	8 children 7 FTEs	0-18	70% 13-15 20% 6-12 10% 16-17	70% Male 30% Female	100% White	65% Emotional 25% Behavioral/Conduct 10% Schizophrenic/Psychotic Will not accept if: o severe substance abuse o severe retardation	6 months - 2 years 30 hours/week with child 3 hours/week with family

DESCRIPTION

- o Uses treatment families
- o Staff work intensively with child, treatment family and birth family
- o Uses family systems model and behavioral techniques
- o Many children are also in day treatment

OBSERVATIONS

- o 100% state Department of Health
- o Agency also provides in-home services, day treatment, wilderness camp, etc.
- o Have follow-up data at 1, 3, 6 months and 1 year

BALTIMORE FAMILY LIFE CENTER, EXTENDED FAMILY PROJECT
Baltimore, Maryland
Reg. III
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	10 children 4 FTEs	15-21	100% 18-21	100% Male	100% Black	50% Behavioral/Conduct 50% Schizophrenic/Psychotic Will not accept: o severe violent behavior o criminal activity	3 years

DESCRIPTION

- o Project provides family therapy, counseling, foster care, individual therapy, referrals and planning to children and families
- o No specific information provided re: foster care services
- o Provides semi-independent living situations in foster homes and independent living situations in apartments

OBSERVATIONS

- o 100% contract for services
- o Serves youth in transition population
- o Has linkages with employment agencies for referral, follow-up, partial payment agreements, etc.
- o Case workers provide case management

BEECH BROOK STAFF HOMES, SPECIALIZED FOSTER CARE PROGRAM
Cleveland, Ohio
Reg. V
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
		46 children 20 homes					Special needs infants and toddlers with physical and/or mental handicaps (Sickle Cell Anemia, etc.) Ed children 5-18 years old Sibling groups Teenage mother/child placements	

DESCRIPTION

- o Specialized foster care for special needs children of all ages
- o Foster parents trained and paid by Beech Brook

OBSERVATIONS

- o Part of Beech Brook which provides residential treatment, day treatment, weekend and summer program, aftercare and outpatient treatment. Gund School on campus

BRINGING IT ALL BACK HOME STUDY CENTER, APPALACHIAN STATE UNIVERSITY, PROFESSIONAL PARENTING
Morganton, North Carolina
Reg. IV
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Public	32 children 5 FTEs	8-18	55% 13-15 25% 16-17 20% 6-12	55% Female 45% Male	92% White 8% Black	70% Emotional 26% Behavioral/Conduct 4% Mental Retardation Will not accept: o active psychosis o moderate to severe retardation o drug addiction	30 months 1 hour/week with child 2 hours/week with professional parents

DESCRIPTION

- o Actively recruits and carefully selects professional parent couples. Provides comprehensive pre-service training and on-going professional consultation
- o Places no more than 2 youths to a home
- o Training and support uses a behavioral orientation
- o Visitation with natural family facilitated when appropriate but in most cases parental rights have been terminated

OBSERVATIONS

- o Operated by University
- o 65% Federal Title IV B funds; 15% Social Service Board payments; remainder state, contracts and state mental health funds
- o Compensates parents $400-$500 per month
- o Provides training in delivering of specialized foster care to other agencies and training in preventing physical and sexual abuse in foster care
- o Study Center also provides group homes and in-home services (Home Remedies)
- o Strong linkage with child welfare
- o Provides case management and advocacy
- o Have evaluation data including annual consumer evaluation of professional parents, pre-treatment and follow-up data on youths

CATHOLIC CHARITIES, THERAPEUTIC FOSTER CARE
Jackson, Mississippi
Reg. IV
Established: 1983

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	25 children 3 FTEs	7-15	87% 6-12 13% 13-15	60% Male 40% Female	34% White 60% Black 6 % Asian	75% Dual Diagnosis 100% Behavioral/Conduct 100% Emotional 2% Schizophrenic/Psychotic 50% Mental Retardation 75% Development Disabilities Will not accept: o active psychosis o moderate to severe MR o severe substance abuse o chronic runaway behavior	10 months 1.5 hours with active psychosis child and family

DESCRIPTION

- Provide therapeutic setting for youngsters with emotional and/or behavioral problems
- Recruit, license and train foster parents in behavior management techniques
- One child per family
- Placement may last 6-12 months
- Therapists work with child, foster family and natural family
- Strong behavioral change model combined with family systems
- Ongoing training and support groups for foster families

OBSERVATIONS

- 85% Department of Mental Health funded
- Provide follow-up services post discharge
- Service contracts with MH and child welfare agencies
- Therapists are "case managers"
- Require involvement of natural families, but don't always provide direct treatment to birth family
- Active in state legislative issues
- Is a model program in the state

CHILDREN'S AID AND ADOPTION SOCIETY, TREATMENT HOME PROGRAM
Bogota, New Jersey
Reg. II
Established: 1975

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Suburban	Private nonprofit	28 children 3 FTEs	5-18	40% 16-17 30% 13-15 15% 6-12	50% Male 50% Female	60% White 30% Black 10% Hispanic	40% Behavioral/Conduct 40% Emotional 20% Developmental Disabilities and combinations of above Will not accept if: o incarcerated delinquent o substance abuse o fire setting o uncontrolled epilepsy o psychotic o overt homosexuality	18 months 1-2 hours with child and family

DESCRIPTION

- Provides protective and rehabilitative services to severely disturbed children in treatment homes
- Recruits, selects, trains and supervises foster families; uses parents as the major therapeutic agents
- Semi-monthly groups with social workers and other treatment home parents
- Parents paid a "difficulty of care" fee for services
- Prepares adolescents for independent living and provides 4 months of paid aftercare with medical benefits and social work supervision

OBSERVATIONS

- 100% state funded
- Social workers see biological families to promote reunification and to provide individual and family counseling
- Emphasize permanency planning
- Agency offers full range of child welfare services, adoption, foster care, day care, group homes, respite treatment homes for disturbed adolescents, pregnant adolescents and young mothers and their babies (Mother/Child Treatment Home Program), post-adoption counseling services
- Linked with CMHCs to provide MH services to clients, linkages with schools, child welfare
- Case management provided
- Active in advocacy at national, state and local levels

CHILDREN'S CENTER OF WAYNE COUNTY, THERAPEUTIC FOSTER CARE
Detroit, Michigan
Reg. V
Established: 1982

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	50 children 4.67 FTEs	2-17	40% 13-15 35% 6-12 20% 16-17 5% 0-5	40% Male 60% Female	95% Black 5% White	50% Emotional 40% Behavioral/Conduct 10% Schizophrenic/Psychotic Will not accept if: o violent behavior o fire setting	10-15 months 3 hours/week with child and family

DESCRIPTION

o No description provided

OBSERVATIONS

o Funded 100% by Department of Social Services

o Agency also has outpatient, day treatment for children and adolescents, group home, emergency services, tutorial program, teenage parent program, etc.

CHILDREN'S SERVICE CENTER OF WYOMING VALLEY, PARENT COUNSELOR PROGRAM
Wilkes-Barre, Pennsylvania
Reg. III
Established: 1979

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	12 children 3.58 FTEs	3-18	50% 6-12 16% 13-15 16% 18-21 8% 0-5 8% 16-17	50% Male 50% Female	100% White	Children must be legal wards of children and youth agencies 25% Emotional 16% Behavioral/Conduct 8% Schizophrenic 16% Adjustment Disorders Will not accept if: o severe substance abuse o severe violence o severe sexual offender o adjudicated delinquents	11 months average (6 months - 2 years) 1.5 hours/week with child 1.5 hours/week with natural family

DESCRIPTION

- Specialized community residential treatment program to serve as alternative to hospitalization
- Program has 12 parent counselor homes. Parents function as group unit and meet twice monthly for discussion/supervision with staff
- One child placed in each home
- Program recruits and trains parent counselors
- Parent counselors function as part of treatment team
- Parent counselors also work with biological family, follow-up visits and support, 24-hour crisis

OBSERVATIONS

- Funded 50% by Children Youth and Families Department foster care, 50% by PA office of MH/MR and county MH/MR program
- Modeled after Parent Counselor Program in Alberta and Parent Therapist Program in Ontario, Canada
- Emphasizes "extended family" system among parent counselors and with biological families
- Agency provides individual sessions for child, outpatient services, partial hospitalization, case management, specialized recreation and many other services
- Agreements with child welfare, juvenile justice, and mental health providers
- Case and class advocacy

CPC MENTAL HEALTH SERVICES, THERAPEUTIC COMMUNITY HOMES
Eatontown, New Jersey
Reg. II
Established: 1983

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	8 children 2 FTEs	6-18	71% 6-12 14% 16-17 14% 18-21	71% Female 29% Male	86% White 14% Black	38% Developmental Disabilities 25% Behavioral/Conduct 25% Emotional 12% Schizophrenic/Psychotic Will not accept: o severely violent behavior o adjudicated delinquency o severe substance abuse o pregnancy o child adamantly opposed to placement	Several years 128 hours/week with child

DESCRIPTION

- Provides residential care in community home with parents trained to provide care
- Uses team approach with family providing treatment, social workers providing supervision, consultation and therapy to youngsters
- Respite worker is assigned to each child to provide 1 to 1 recreation and respite
- Provides residential care, crisis intervention, pre-service training to families, supervision and support of families, therapy, respite care, visitation with natural family, liaison to community agencies, preparation for adoption
- Uses behavior management/reward system

OBSERVATIONS

- Funded 100% by New Jersey Division of Youth and Family Services
- Formalized affiliation with child welfare agency
- Provides case management and case advocacy
- Involves natural family in child's treatment
- Does not have stringent eligibility criteria. Will accept and design a program for a child if the child can grow in an open community setting
- Agency also has 2 schools for SED children (Elementary, Junior HS & HS), groups homes, summer day camp (Camp High Point), partial hospitalization program, outpatient psychiatric/psychological services, crisis services, in-home services (community alternatives), pediatric liaison service (psychologists placed in pediatricians offices), student assistance program for substance abuse, TOTLINE, consultation to preschools, day care centers and schools, program for adolescent sex offenders, etc.
- Has comprehensive network of services

DANIEL MEMORIAL, CAREER PARENTS PROGRAM
Jacksonville, Florida
Reg. IV
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	10-12 3.75 FTEs	5-18	50% 13-15 40% 6-12 10% 0-5	60% Male 40% Female	90% White 10% Black	40% Behavioral/Conduct 40% Emotional 10% Schizophrenic/Psychotic 10% Dual Will not accept: o moderate/severe retardation o sex offenders o serious violence	18 months At least 1 hour with child and family

DESCRIPTION

- Recruits and trains foster parents and provides monthly in-service training
- Places SED children in foster homes and develops and implements a home treatment program
- Staff provide on-going support for child and foster parents and coordinates all needed services
- Provides respite services for foster families and 24-hour crisis intervention
- Does home studies for licensures and relicensure of foster homes

OBSERVATIONS

- Funded 90% by Florida Department of HRS, 10% United Way
- Behavioral philosophy skill development approach
- Agency has long-term residential services for latency age and adolescent SED children and has therapeutic group home for girls
- Linkages with school, affiliate agreement with substance abuse agency
- Case management provided by foster care specialists
- Case advocacy, some class advocacy with legislators
- Are implementing independent living program for older adolescents
- Developing homes to work intensively with "acting out" child

DIVERSIFIED HUMAN SERVICES, HOST FAMILY RESIDENTIAL PROGRAM
Monessen, Pennsylvania
Reg. III
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	10 children 2 FTEs	11-17	65% 13-15 25% 16-17 10% 6-12	50% Male 50% Female	100% White	Child must be adjudicated dependent and have primary MH diagnosis: 50% Emotional 30% Behavioral/Conduct 10% Dual Will not accept: o actively psychotic (place after acute hospitalization) o assaultive children accepted with voluntary behavior contract	6 months - 2 years 2 hours/week with child 1 hour week with family or less depending on need

DESCRIPTION

- o Provide living accommodations with maximum supervision and full range of psychosocial rehabilitative services for youth 4-17
- o 20-hour parent-counselor pre-certification training
- o In-home support and intervention with natural families, after care following return (up to 3 months)
- o Regular meetings of host families and respite for each other
- o Blend of cognitive and behavioral interventions
- o Peer counseling; between host and natural parents
- o Program staff available to host families
- o 24-hour crisis

OBSERVATIONS

- o Funded by state office of MH 100%
- o Program result of joint funding/administrative effort of Children and Youth - MH/MR agencies in 4 counties
- o Other programs offered by agency include outpatient services, early intervention program
- o Linkages with school, child welfare, etc.
- o Provides case management
- o Engage natural families in service agreement
- o Provide in-home consultation, parenting training and peer counseling
- o Host families viewed as paraprofessionals and integral part of treatment team

EAST ARKANSAS REGIONAL MENTAL HEALTH CENTER, THERAPEUTIC FOSTER CARE
Helena, Arkansas
Reg. VI
Established: 1979

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Private nonprofit	24 children 21 homes 7 FTEs	0-17	25% 6-12 46% 13-15 25% 16-17	50% Male 50% Female	54% White 46% Black	Not provided Will not accept if: o fire setters o actively psychotic youth prior to inpatient treatment o mentally retarded Serves youth with severe behavioral and emotional problems compounded by other disabilities (MR, epilepsy, diabetes, etc.) - Multi-problem youth	3 years 2 hours/week with child and family

DESCRIPTION

- Treats "difficult to place" youth in natural family setting with trained therapeutic foster parents
- Recruits, selects and trains families
- Families under contract to EARMHC
- Provides on-going monthly training
- Weekly in-home visits to parents from professional staff to monitor treatment plans, support parents, coordinate other needed community services
- Family therapist works with natural parents

OBSERVATIONS

- Contracts with Arkansas Division of Mental Health and Division of Child/ Family Services to provide therapeutic foster care
- Serves multiproblem youth with history of failure in other placements, "high risk youth" for long-term institutionalization
- Staffing with school. Referral relationships with other agencies
- Until 1984 only served youth in custody of Social Services. Converted 6 bed residential program to therapeutic foster care program to serve youth not in custody
- Also have "specialized foster homes" for handicapped, neglected abused youth
- Evolved from a therapeutic group home to create smaller, less restrictive family-oriented settings
- Emphasizes natural, family environment
- Evaluated annually by state

FAMILY ALTERNATIVES
Minneapolis, Minnesota
Reg. V
Established: 1979

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	35 children 2.5 FTEs	1-21	29% 13-15 23% 6-12 19% 16-17 16% 0-5 13% 18-21	50% Female 50% Male	100% White	75% Emotional 75% Developmental Disabilities 50% Behavioral/Conduct 25% Substance Abuse 10% Schizophrenic/Psychotic	18 months 2 hours/week with child

DESCRIPTION

- o Licenses foster families, provides ongoing training in all areas of child care and supervises placements of children with behavioral and emotional problems who can benefit from home-like environment
- o Social workers supervise foster parents

OBSERVATIONS

- o Funded 100% by county social services purchase of services
- o Little work with child's natural family. County social services works with family
- o Philosophy emphasizes family-based treatment model
- o Joint planning and staffing with schools
- o Service contracts with social services and juvenile justice
- o Belongs to a lobbying association
- o Provides case management - placement plan with 3 month reviews
- o Linkage with VR

FAMILY & CHILDREN'S SERVICES OF THE KALAMAZOO AREA, TREATMENT FOSTER CARE
Kalamazoo, Michigan
Reg. V
Established: 1982

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	27 children 7 FTEs	6-18	40% 6-12 35% 13-15 25% 16-17	50% Male 50% Female	85% White 13% Black 1% Hispanic 1% Native American	60% Emotional 35% Behavioral/Conduct 5% Schizophrenic/Psychotic Will not accept: o violent behavior o active psychosis o severe substance abuse o actively suicidal	1 year 2 hours/week with child, natural family, and foster family

DESCRIPTION

- Provides specialized foster care homes for children with serious emotional impairments with one child per family
- Provides one 6-bed family group home
- Services include case management, individual and family therapy, psychiatric consultation, crisis intervention, educational coordination, foster parent training and therapeutic milieu in the foster home

OBSERVATIONS

- Funded 80% by community mental health funds, 20% by State Department of Social Services
- Provides case management and advocacy
- Agency also provides individual and family treatment through Family Services Unit, in-home services (Home-Community Intervention Program) Valley Center outpatient and day treatment programs (after school and summer)
- Provides treatment to biological families including consultation, referral, family counseling and outreach
- Has single entry system and defined system of care coordinated by mental health board

HUMAN SERVICE ASSOCIATES
St. Paul, Minnesota
Reg. V
Established: 1979

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private for-profit	90 children 7 FTEs	0-19	30% 13-15 22% 0-5 21% 6-12 21% 16-17	63% Male 37% Female	62% White 27% Native American 10% Black	33% Dual Diagnosis (mostly behavioral and emotional) 22% Emotional 14% Behavioral Will not accept if: o severely violent behavior	3-18 months

DESCRIPTION

- o Specialized foster family care for youth considered inappropriate for regular foster care but who do not require structure of institutional setting
- o Provides training for foster parents
- o Features 1) contracting - social worker, client and all others develop written service contract; 2) networking - assist birth parents and foster parents to work together; 3) foster parent support systems - support group meetings; and 4) mobilizing community resources
- o Has recruited families with wide diversity in experience and cultural origin

OBSERVATIONS

- o Formal contracts with child welfare, joint planning, communication, referrals with others
- o Case management
- o Case advocacy and involvement with legislative issues
- o Birth parents encouraged to be part of planning/staffing team. "Team" concept in plan development
- o Offers respite services to parents and foster parents
- o Developing an independent living skills program for youths ages 16 - 18

HURON RESIDENTIAL SERVICES FOR YOUTH
Ann Arbor, Michigan
Reg. V
Established: 1969

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	40 children 10 FTEs	5-18	40% 16-17 60% 12-15	60% Male 40% Female	40% White 60% Black	85% Emotional 10% Borderline 5% Substance Abuse Will not accept if: o regular violent behavior o severe substance abuse o involuntary	2-5 years 24 hour supervision by foster parents 2 hours/week with child and foster family 2 hours/month with natural family

DESCRIPTION

- Residential treatment program using network of community-based facilities and token economy - behavior modification program
- After completing residential treatment program offer 1) specialized foster care program and 2) supervised independent living program
- Little information provided about foster care component

OBSERVATIONS

- Funded by Michigan social service, Department MH and county
- Service contract for foster care by juvenile justice
- Case management
- Have family therapist who meets with natural families a minimum of once/month. Families involved in case reviews
- Have survival skills class for youth entering independent living and a pre-supervised independent living experience
- Have in-house school

KALEIDOSCOPE, THERAPEUTIC FOSTER FAMILY PROGRAMS
Bloomington, Illinois
Reg. V
Established: 1973

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	92 children (+ 12 children of children) 63 homes 20 FTEs	0-21	40% 16-17 35% 13-15 15% 0-5 5% 6-12 5% 18-21	55% Female 45% Male	65% Black 30% White 5% Hispanic	60% Behavioral/Conduct 30% Dual Diagnosis (Behavioral and Emotional or Physical Disability) 5% Emotional 5% Schizophrenic/Psychotic Will accept any child regardless of behavior or handicap	1-3 years

DESCRIPTION

- Provides 50 therapeutic foster homes in which one foster parent is available full time
- Operates 12 therapeutic foster homes for pregnant teenagers or teen parents and their babies
- Operates one hybrid foster home with foster parents, 2 child care workers and 4 children
- Methods include behavior modification, psychotherapy, medical treatment, therapeutic case management, etc.
- Will not discharge children for misbehavior or severe handicaps

OBSERVATIONS

- Funded 97% by State Department of Children and Family Services
- Philosophy is normalization and accentuating the positive
- Kaleidoscope also offers in-home services (Satellite Family Outreach), Youth Development Program for supervised independent living skills
- Provides case management and advocacy
- Few children have biological families. When they do, family are involved in planning and visitations

LEE MENTAL HEALTH CENTER, FAMILY NETWORK PROGRAM - THERAPEUTIC FOSTER CARE AND INDIVIDUAL RESIDENTIAL TREATMENT (IRT)
Fort Myers, Florida
Reg. IV
Established: 1976

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprivate	38 children 7 FTEs	4-18	40% 13-15 30% 6-12 30% 16-17	60% Male 40% Female	80% White 10% Black 10% Hispanic	60% Emotional 40% Behavioral/Conduct Will not accept if: o severe substance abuse o mentally retarded	12 months TFC: 2 hours with child 1 hour with family IRT: 4 hours with child 2 hours with family

DESCRIPTION

- o 5 clusters of therapeutic foster homes (33 homes) providing intensive services to ED children
- o Usually 1 child per foster home with $150 stipend paid by MH above HRS board payments
- o IRT is more intensive version (24-hour supervision) of Family Network. Extra support and training for foster parents
- o Foster parents visited weekly and receive ongoing training and support 24-hour back-up
- o Provides treatment to natural parents and follow-up services

OBSERVATION

- o Funded 85% by Florida Department of HRS, 15% county
- o Close link with school - one staff person assigned to school full time (works with schools and teachers)
- o Good linkage with juvenile justice, monthly meeting with HRS units (court and judges order children to the program)
- o Comprehensive MH services offered by Lee MHC
- o Have independent living program that can last through age 19 for youths not returning home
- o 20 programs like this now operate in Florida
- o Emphasize contact between foster parents and natural parents

LUTHERAN SOCIAL SERVICE OF IOWA, FOSTER CARE
Des Moines, Iowa
Reg. VII
Established: 1940

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	30 FTEs	0-21	26% 16-17 23% 18-21 19% 13-15 17% 0-5 15% 6-12	61% Male 39% Female	51% White 38% Asian 10% Black 2% Hispanic	97% Dual Diagnosis Behavioral/Conduct and Emotional Disorders Will not accept if: o psychotic o violent behavior	1 year 2/hours/week with child and family

DESCRIPTION

- o Recruits and licenses foster homes
- o Trains foster parents (12 hours) and provides ongoing support and supervision
- o Staff supervise placement of children in foster homes
- o Therapy services provided to child and to natural family for parent skill development
- o Provides support group for foster families and children

OBSERVATIONS

- o Funded 96% by Iowa Department of Human Services (POS)
- o Serves substantial number of refugees
- o Emphasizes family systems and behavior modification approaches
- o Agency provides a continuum of care including foster care, in-home services, group home and residential treatment
- o Has half-time lobbyist

NORTHEAST MENTAL HEALTH CENTER, SPECIALIZED FOSTER CARE

Memphis, Tennessee
Reg. IV
Established: 1974

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	30 children 4 FTEs	2-17	60% 6-12 25% 0-5 10% 13-15 5% 16-17	60% Male 40% Female	45% White 45% Black 5% Asian 5% Hispanic	80% Behavioral/Conduct 20% Emotional Will not accept: o retardation (IQ below 70) o psychotic o major drug abuse problem o chronic runaway o serious physical aggression	12 months 1 hour/week with child 1.5 hours/week with family

DESCRIPTION

- o Provides foster care as alternative to institutionalization
- o Recruits and selects foster parents
- o 30-hour training program for foster parents and monthly in-service in behavior modification techniques
- o Weekly consultation for foster parents with trained behavioral therapist

OBSERVATIONS

- o Funded 47% Title XX, 44% State DHS, 9% Medicaid
- o Linkages with schools, child welfare
- o Case management provided
- o Natural families take part in family counseling and parent training
- o Two-thirds children served were placed in less restrictive environments. Only 10% hospitalized $5,480/child/year is unit cost

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NORTHEASTERN FAMILY INSTITUTE, PROFESSIONAL FOSTER CARE
Burlington, Vermont
Reg. I
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	10 children 9 homes 13 FTEs	13-17	50% 13-15 50% 16-17	50% Male 50% Female	100% White	100% Emotion Will not accept primary diagnosis of: o mental retardation o severe substance abuse o delinquency o serious neurological impairment o autism	1-2 years

DESCRIPTION

- o NFI recruits education and human service professionals to work with youth in their homes
- o Professional parents receive weekly staff supervision and attend monthly training
- o Family therapy provided to natural families, families involved in service planning
- o 24-hour back-up provided

OBSERVATIONS

- o 50% Medicaid Waiver DMH and 50% Department Social Services
- o Case management provided and advocacy
- o Agency also has group home, emergency bed, professional parent homes and a special ed program in affiliation with public school
- o Emphasis on involvement of natural family
- o Has 1 emergency bed that has virtually replaced use of State Hospital for adolescents with maximum stay of 10 days

PATH (PROFESSIONAL ASSOCIATION OF TREATMENT HOMES)

Minneapolis, Minnesota
Reg. V
Established: 1972

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	155-170 children 90 homes 12 FTEs	0-18	35% 13-15 30% 16-17 20% 6-12 10% 0-5 5% 18-21	48% Male 52% Female	80% White 10% Native American	70% Dual Diagnosis Diagnosis not used as basis for placement 80% Emotional 70% Behavioral 50% Developmental Disabilities 40% Substance Use Will not accept if: o violent o actively suicidal o sexually or physically abusive of other children	9 months

DESCRIPTION

- Have 95 treatment foster families. Most families have no more than 2 children
- Provides foster family-based treatment in four areas in Minnesota
- PATH recruits foster parents, provides a minimum of 30 hours of training annually and provides regular support group meetings
- Uses explicit written placement contract for each child, reviewed every 3 months
- PATH is governed by a Board primarily comprised of member foster parents

OBSERVATIONS

- Funded by fees charged to agencies placing children
- 11 FTE professional staff, 2 contract psychologists
- Treatment structured individually to meet the needs of the child
- PATH social worker provides case management
- Natural families involved in care plans and service delivery
- Case advocacy and members of advocacy groups
- Uses treatment team made up of natural parents, foster parents, PATH Social Workers, therapists, school personnel etc. to develop and review plan
- Linkages with all community resources
- Costs $37.25/day

PEOPLE PLACES
Staunton, Virginia
Reg. III
Established: 1973

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Private nonprofit	52 children 19 FTEs	0-18	34% 6-12 27% 16-17 26% 13-15 13% 18-21	66% Male 34% Female	72% White 17% Black 9% Native American 2% Asian	75% Behavioral/Conduct 25% Emotional Will not accept: o serious violence o strongly resistant adolescents o severe retardation with serious behavior problems	18-20 months 2.5 hours/week with child .5 hour/week with biological family

DESCRIPTION

- o Provides community-based residential treatment in "teaching parent homes"
- o Recruits, screens and trains foster parents with 18-hour Parenting Skills Training Program focusing on 14 care skills
- o Uses behavior management approach
- o Provides professional support to teachers/parents for training, support and supervision
- o Teaches behavior management skills to biological families as well and provides aftercare consultation

OBSERVATIONS

- o Funded 75% by Title XX
- o One of the oldest therapeutic foster care programs in the country
- o Offers independent living skills and pre-vocational training for older adolescents
- o Service contracts with schools, child welfare
- o Case management
- o Emphasizes normalizing, family environment
- o Offers special education day program (Pygmalion School)
- o Placement decisions made by committee

PRYDE (PRESSLEY RIDGE YOUTH DEVELOPMENT EXTENSION)
Pittsburgh, PA
Reg. III
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban PA Rural WVA	Private nonprofit	120 children 31 FTEs	3-18	35% 6-12 27% 16-17 12% 18-21 5% 13-15	51% Male 49% Female	Pittsburgh: 65% Black 35% White Sewickley: 100% White West Virginia: 100% White	30% Emotional 70% Behavioral/Conduct 1% Schizophrenic/Psychotic Will not accept if: o extreme violence o recent, frequent fire setting o severe retardation o active severe psychosis Intensive version of PRYDE can serve youth with more severe problems.	15 months 1/2 hour/week with child 1.5 hours/week with natural and treatment parents

DESCRIPTION

- o Recruits, trains and supports parents - 6-week pre-service training, monthly in-service and in-home individualized training
- o Treatment parents are considered the agents of behavior change
- o Philosophy of treatment is "re-education"
- o Daily treatment plan is implemented by PRYDE parents with specific daily goals
- o Provides support groups, training groups and in-home assistance to natural parents
- o Post-discharge services
- o Respite provided

OBSERVATIONS

- o Funded 50% by state 50% by County in PA, 100% by state in West Virginia
- o Also have Pressley Ridge Day School (day treatment program), wilderness school, and Status Offender Program in West Virginia
- o Case management provided by Parent Supervisors/Comm. Liaisons
- o Linkages with schools, child welfare, mental health, etc.
- o Emphasizes working with natural families to enhance successful reunification. Offers parent groups, regular contact with parent supervisor, parent skills training, life skills training and interaction between natural and PRYDE parents
- o Has computerized evaluation data

RAINBOW MENTAL HEALTH FACILITY, PARTNERS IN PARENTING
Kansas City, Kansas
Reg. VII
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	11 children 2 FTEs	13-17	50% 13-15 50% 16-17	25% Male 75% Female	62% White 25% Black 13% Asian	63% Behavioral/Conduct 37% Schizophrenic/Psychotic	Probably 1 year or more (unknown as yet) 1 hour with child and family

DESCRIPTION

- o Provides specialized therapeutic foster homes for ED children in hospitals and group care who cannot return home
- o Families selected and trained - 33 hours pre-service, 3 hours/month in service
- o Staff visit child and foster family weekly and more when needed
- o Respite available and child and family see private therapist weekly
- o Currently have 9 homes, plan to grow to 18-20

OBSERVATIONS

- o Funded by state, Medicare, Medicaid and fees
- o Agency is a psychiatric hospital and provides full range of services
- o Linkage with schools - teacher from agency school works with teachers in community schools, has contracts with two CMHCs to provide treatment to children
- o Provides case management
- o Sponsored by Kansas Department of Social and Rehab. Services

STARR COMMONWEALTH SCHOOLS, HANNAH NEIL CENTER FOR CHILDREN, SPECIALIZED FOSTER CARE
Columbus, Ohio
Reg. V
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	4 children 2 homes 1 FTE	4-18	80% 6-12 15% 13-15	65% Male 35% Female	50% White 50% Black	65% Behavioral/Conduct 35% Emotional Will not accept if: o active psychosis o severe mental retardation o severe physical disability o seriously violent behavior	8 months 1.5 hours with child and family

DESCRIPTION

- Family-based intensive treatment program for children with emotional and behavioral problems
- Screen and train foster parents who work with therapist to provide therapeutic services to child and natural family
- Philosophy is to nurture family relationships, treatment emphasis on family therapy and strategic family therapy
- Have specialized foster care operating on 3 campuses of Starr Comm. schools, clinic providing outpatient mental health services to children and families

OBSERVATIONS

- Funded by county mental health and county social service agency contracts
- Have support of other agency staff
- Projected capacity 32 homes. Currently have 2 homes
- Strong emphasis on foster parents developing highly constructive relationship with child's family
- Hannah Neil Center has a residential treatment program for 48 ED children with 1 year ALOS, day treatment, and family and child guidance
- Specialized foster care program designed to be link in continuum
- Service contracts with child welfare, linkages with schools
- Case management provided by foster care coordinator
- Advocacy - member Ohio Association of Child Caring Agencies
- Have evaluation data compiled by Director of Research and Evaluation

TRANSITIONAL RESIDENCE INDEPENDENCE SERVICE (TRIS), SPECIALIZED FOSTER CARE

Stratford, New Jersey
Reg. II
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	25 children 2 FTEs	6-19	60% 6-12 20% 16-17 10% 13-15 10% 18-21	60% Male 40% Female	95% White 5% Black	32% Emotional 23% Schizophrenic/Psychotic 45% Other (School problems, abuse, neglect, marital/family problems Will not accept: o mental retardation o severe substance abuse o autism o social maladjustment without psychiatric diagnosis	10 months 2-3 hours/week with child 1 hour/week with family

DESCRIPTION

- Identifies, recruits, trains and certifies foster parents in conjunction with Division of Youth and Family Services
- Provides ongoing technical assistance to foster parents
- TRIS philosophy centers around developing a trusting relationship with the client, helping client to identify realistic goals and providing an accepting milieu to practice newly learned behaviors

OBSERVATIONS

- Funded 100% by New Jersey Division of Mental Health and Hospitals
- Provides case management and case advocacy
- TRIS also offers Childrens Crisis Intervention Service (CCIS), Interim Group Home, adolescent partial care program (day treatment)
- TRIS serves children and adolescents, young adults with severe and chronic psychiatric problems and severely chronic, long-term adult clients

TRI-COUNTY YOUTH SERVICE, NEXUS FOSTER CARE & ALTERNATIVE LIVING FOR YOUTH (ALY)

Northampton, Massachusetts
Reg. I
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	40 children 7 FTEs	12-24	60% 16-17 30% 13-15 9% 18-21	67% Male 33% Female	75% White 15% Black 10% Hispanic	100% Emotional 45% Behavioral/Conduct 20% Schizophrenic/Psychotic Will not accept if: o actively suicidal o violent o mentally retarded o fire starters	6-12 months 3 hours with child/week 3 hours with family/week

DESCRIPTION

- Specialized foster care program
- Nexus program provides residential and day treatment for adolescents in custody of DYS or DSS
- Alternative for Living (ALY) programs are intensive foster care programs designed to serve as alternatives to residential placement or hospitalization
- Provides foster homes, foster parent training, individualized treatment plan, case management, day programs with educational and vocational components, etc.

OBSERVATIONS

- Funded 45% by Massachusetts Department Youth Services, 40% by Department of Mental Health, 15% Department of Social Services
- Case managers have 6-8 clients - daily contact with foster parents
- Natural families included as part of service and treatment plan
- Case advocacy, court-related
- Tri-County is multiple service agency for adolescents offering intensive foster care for ED children, and schools for SED and court-involved children, day treatment
- Provides aftercare services as bridge for youth moving from foster care to independent living

VENTURA COUNTY MENTAL HEALTH SERVICES, VENTURA COUNTY CHILDREN'S MENTAL HEALTH DEMONSTRATION PROJECT, SHOMAIR-ENRICHED FOSTER CARE
Ventura, California
Reg. IX
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	15-18 children 2.8 FTEs	3-18				40% Behavioral/Conduct 40% Emotional 10% Schizophrenic/Psychotic Will not accept: o mental retardation o active psychosis o severe substance abuse	12-18 months 1-2 hours/week with child and family

DESCRIPTION

- o Provides intensive services in selected foster homes. Provides in-home therapy for children and consultation and support for foster parents
- o Foster parents considered members of the treatment team and may serve as training parents for the natural family
- o Treatment approach emphasizes family systems
- o Provides consultation to child protective services and coordinates services with school system and other professionals

OBSERVATIONS

- o 100% State funded
- o Provides case management
- o Natural parents receive individual or family therapy and may receive training and support from foster family
- o Collects behavioral checklist data on children entering and terminating the program as part of project evaluation
- o Part of Ventura County Demonstration project with comprehensive system of children's mental health services
- o County has 10.5 FTE case managers ("brokers") to coordinate full continuum of services and interagency network
- o Other services provided include emergency services, youth center, mental health services to juvenile hall, group homes, day treatment, outpatient servcies, case managements, prevention, etc.
- o County has interagency policy council, interagency case management council, written interagency agreements and interagency service approaches

WAKE COUNTY JUVENILE TREATMENT SYSTEM, ONE ON ONE PROGRAM

Raleigh, North Carolina
Reg. IV
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	19 children	6-18	40% 13-15 40% 16-17 40% 18-21 10% 6-12	75% Male 25% Female	50% White 50% Black	75% Behavioral/Conduct 15% Emotional 5% Mental Retardation 5% Developmental Disabilities Will not accept: o actively psychotic or suicidal o clearly dangerous to others o poor fit between available coaches and child	1-10 months 24 hours/week with child 1-2 hours/week with family as needed

DESCRIPTION

- Contracts with individuals to provide care and treatment in their homes
- Providers are called "coaches", hold no other job and are available to meet treatment needs of youth. Emphasis is on treatment and corrective relationship between youth and coach
- Provides specific treatment required by child, crisis intervention, family therapy

OBSERVATIONS

- 100% State funds
- Coordinator and coach are members of child's "individual habilitation team"
- Natural families involved, coaches establish relationships with natural parents
- Juvenile Treatment System provides case management, individual and family habilitation planning team, secure residential treatment, high management group homes, moderate supervision group homes, supervised apartment living, day treatment, in-home services, individual, group and family therapy and vocational services

WEST VIRGINIA YOUTH ADVOCATE PROGRAM
Wheeling, West Virginia
Reg. III
Established: 1983

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	45 children 8 FTEs	0-21	41% 16-17 22% 6-12 16% 18-21 15% 0-5 6% 13-15	44% Male 56% Female	99% White 1% Native American	62% Other (abuse/neglect, sexually abused, etc.) 12% Emotional 16% Behavioral Will not accept: o dangerous to self or others o arsonists	6-12 months 1 hour/week with child plus 5 hours/week with advocate 1 hour with family

DESCRIPTION

- o Provides specialized foster care, therapeutic foster care and pre-independent living programming
- o Provides advocate to work 5 or more hours per week with youth and foster family
- o Foster parents screened and licensed, 6-8 hours preservice training, monthly inservice training
- o Area coordinator visits regularly (staff)
- o Advocacy model - one adult working with youth in positive relationship
- o Have "personal progress plan" with goals in 8 areas

OBSERVATIONS

- o Funded by West Virginia Department of Human Services - 100%
- o Agency provides home advocacy (in-home) services to prevent out-of-home placement specialized foster care, special residential advocacy (1-1 staff support for very difficult youth), pre-independent living and independent living services for youth in transition
- o Provides case management and case advocacy
- o SRA (special residential advocate) also called "professional foster parent" or "treatment foster home"
- o Has Emergency Shelter care (short-term crisis)

YOUTH ALTERNATIVES OF SOUTHERN MAINE, FAMILY SERVICES
Portland, Maine
Reg. I
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	21 children 3 FTEs	12-18	80% 16-17 20% 13-15	50% Male 50% Female	100% White	80% Behavioral/Conduct 20% Emotional Will not accept: o arson o severe violent behavior o severe mental retardation o actively suicidal	1 year 3 months 2 hours/week with child 4 hours/week with foster family

DESCRIPTION

- o Recruits, screens and provides training and supervision to foster parents
- o Provides counseling and 24-hour emergency availability
- o Foster care program also has a short-term emergency component

OBSERVATIONS

- o Funded 70% by Maine Department of Human Services, 30% by Title IV
- o Provides case management and advocacy
- o Agency has continuum of services for children including emergency shelter, therapeutic group home (ROADS)

APPENDIX A

THE STORY OF AMANDA

Prepared by:

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E. Mary Grealish, Director of PRYDE Model Implementation
The Pressley Ridge Schools

In summarizing his thoughts about 10-year old Amanda Shaw, the chief psychologist at Northmont Children's Home concluded, "This kid is crazy." Amanda was one of 68 residents at the home for emotionally disturbed children. Since her placement nine months earlier, Amanda's behavior had deteriorated rapidly. She had become violent, destructive, and uncontrollable, requiring intensive, one-on-one supervision. The consulting psychiatrist had prescribed a program of Haldol and Cogentin but discontinued both drugs after observing no appreciable changes in Amanda's behavior. The conclusion of Amanda's team, which included Northmont's psychologist, consulting psychiatrist, counselors, teachers and supervisors, as well as Amanda's caseworker, was unanimous. Although moving Amanda for the sixth time would most likely compound her problems, Amanda could no longer stay at Northmont.

Amanda's caseworker, Rob Kelly, began advocating for a less restrictive placement. His opinion was received with incredulity by the staff, with the exception of Jean Conroy, who had been Amanda's counselor for nine months. Although she carried more scars from Amanda's violence than any other staff member, Jean joined Rob in his hope that Amanda would be placed in Home Works, a therapeutic foster care program. The psychologists and counselors who were arguing against a therapeutic foster care placement agreed with the ideals of the program but felt its aspirations were higher than its potential.

In a staff meeting to discuss Amanda's future, the psychologist presented excerpts from Amanda's records and called upon staff members to support his case for Amanda's placement in a psychiatric institution. He pointed to the psychiatric evaluation of Amanda as having an oppositional disorder and mild mental retardation, and describing her as a victim of physical and sexual abuse who had suffered prolonged emotional trauma.

A counselor who worked daily with Amanda documented 8 to 14 restraints a day. She described Amanda's aggression as sneaky, like pulling the hair of an unsuspecting playmate, or intense, like scratching, biting and kicking. Her violence was directed at peers as well as adults, but she became particularly aggressive when she was physically restrained for her own and other's safety. Unable to win her physical battle against the counselors, she lashed out with obscenities. The staff reported that most outbursts occurred without observable provocation.

The counselor also described personal weaknesses that made Amanda difficult to care for. She suffered from nightly enuresis and nightmares, had terrible hygiene and no table manners, and was a threat to personal property, including the toys of her playmates as well as the furnishings in the room.

Despite the strong arguments of the professionals who worked with Amanda, her caseworker believed that therapeutic foster care was not only the best choice for Amanda, but offered the only chance for this ten-year old to learn to live an everyday life in an everyday community. Rob Kelly was familiar with therapeutic foster care because several seriously disturbed youngsters who had been in his caseload were now functioning successfully in Home Works. Not only would Home Works provide intensive treatment within the structure of a stable foster family, but a day treatment program would also be available to provide the highly specialized education services Amanda needed.

Before adjourning the staff meeting, Rob asked the counselor who had worked with Amanda the longest to describe the ten-year old in her own terms. Jean Conroy admitted that nothing she had heard at the staff meeting about Amanda was untrue or exaggerated. Amanda was truly a troubling child. But Jean wanted to recognize Amanda's other qualities. Her description of Amanda could not be found in the record books. She described a pretty, hazel-eyed blonde with an engaging smile. Like any other ten-year old, Amanda loved to ride a bike and run about playing and singing. She had dreams of a happy family and friends. Jean talked about the quiet moments at night before bedtime, when Amanda would ask for a story and climb onto Jean's lap, clutching a small, tattered blanket. She would get so close that Jean could feel her heart beating. But it was a seldom-seen side of Amanda, and as her behavior worsened, images of this ten-year old as an innocent child faded. The struggle for a less restrictive placement would be a difficult one, but there was a positive sign: Home Works was willing to accept Amanda.

Even with acceptance, the controversy over Amanda Shaw's referral continued for several months. She could no longer remain at Northmont and most likely would be referred to a psychiatric institution for long-term care, but Rob Kelly had not given up the battle for a less restrictive placement.

If the controversy was settled in favor of therapeutic foster care, Amanda would offer the greatest challenge that Program Director Janet Means had experienced within Home Works. Because the placement was still being disputed, Janet had no formal referral information about Amanda. But Amanda's younger sister, Carrie, had been in a Home Works treatment home with Leslie and Dan Wagoner for a year, and Janet was fully aware of the Shaw children's history and the events in their lives that contributed to such profound emotional problems. She wanted to accept Amanda as a challenge to the flexibility of the program.

Amanda's most elaborate fantasy was that she was part of a happy family that included a mother and father, two little girls, a puppy and a cat. Reality was her nightmare. An alcoholic and alleged prostitute, her mother was serving a two-year prison sentence for neglect and endangerment. Her father, a drug and alcohol abuser, was serving a 20-year jail term for sexual abuse. Both her maternal grandmother and uncle had committed suicide; at age four Amanda had found her uncle hanging from the rafters in the basement of her home.

Many professionals, including the juvenile court judge, found the abuse suffered by Amanda and Carrie to be the worst they had ever encountered. The parents provided little food for the children and kept the refrigerator chained and locked. Only the father had the key. To survive, the children would eat whatever they could find, including raw meat and dog food. One neighbor testified that she often fed the children through the back fence; they were too filthy and lice-ridden to let into her home.

Amanda and Carrie were punished for the misbehavior by being tied up, locked in closets or in the basement, sometimes for days at a time. Their bodies were permanently scarred from being beaten with sticks and from being burned. For years, both girls had been sexually abused by their father. He admitted having sexually abused Carrie when she was three months old. Neighbors and friends of the Shaws had also physically and sexually abused both children, in full view of each other, with adults watching and taking pictures. There had even been allegations of forced intercourse with animals.

Both Carrie and Amanda carried physical and mental scars from the years of abuse, but the results of the abuse and neglect on Amanda were more extreme. Being the older sister, Amanda assumed the role of primary caretaker. In essence, she became Carrie's mother. Carrie was doing well in her Home Works home, but that offered no assurance that Amanda would be as manageable. Her behavior was more erratic and violent. But Janet was used to facing challenges and so were the treatment parents she had trained. Their program was based on the philosophy that behavior, good or bad, was learned, and children could change through reeducation. Amanda had nothing to lose by trying, but everything to lose if they did not try. The final decision would be made by the courts.

Skepticism among the professionals involved ran high in Amanda's case. What parents of sound mind would accept a youngster who bit, kicked, hit, spit on and shouted obscenities at the very people who cared for her! What parents would take a child who required up to 14 restraints a day or open their home up to destruction by an uncontrollable 10-year old!

Leslie and Dan Wagoner first encountered Home Works in 1982 when their neighbors graduated from the required preservice training and took a 15-year old boy into their home. Leslie helped her friends master the practical skills that Home Works taught and watched the solid and immediate support from staff that this family received when the troubled boy arrived. She was thrilled to hear of each success he experienced, and felt that she had contributed to his eventual happiness in a small way. Seeing the impact their neighbors and community had on this boy made the Wagoners decide to join the program, too.

The application process was lengthy. Leslie and Dan completed a detailed written form. The next step was an interview. The Home Works' Parent Supervisor who interviewed Leslie and Dan was extremely positive about their potential as treatment parents. She found them to be well-educated, with a comfortable income, and both were mentally healthy. They seemed to have a good marriage with strong family and community ties. Both seemed flexible, had a good sense of humor, and expressed a willingness to adopt new methods for parenting a troubled child. When the Parent Supervisor made her home study at the Wagoners, she found it to be in a good neighborhood. It was clean and bright, and organized with children in mind. It was also large enough to accommodate one or two additional youngsters without renovation. During the home study a group of teens passed through the house with the Wagoner's son and daughter. The Parent Supervisor from Home Works observed the couple's relationship and parenting ability with their own children. They were warm and affectionate, but firm -- definitely in control. If their references were in order, they could begin training. The Parent Supervisor had rejected the application of two other candidates she had visited that day. One wanted to rely on the Home Works payment for her family's sole income; the other couple seemed to think they had nothing to learn about parenting. The Wagoners were a welcome change. Leslie and Dan successfully served three other troubled children before Amanda came to their attention.

On the day of the hearing, 10-year old Amanda Shaw entered the courthouse, still the subject of a major controversy. She smiled broadly at Judge Wilson as he walked through the room where she would wait during the hearing. The judge knew Amanda well. He had terminated the Shaw's parental rights and had recommended a 20-year jail sentence for her father. Having been involved in all of Amanda's placements, he was sorry to see this child in front of him again.

The hearing was long and, at times, heated. Staff members from Northmont had documented carefully all of Amanda's behavior problems, which clearly showed that Amanda's violence and aggression had escalated even though trained staff were implementing an intensive treatment plan. The evidence was impressive; the psychologist's presentation was eloquent. Those who were advocating for Amanda's placement in a psychiatric institution had offered a strong case.

Amanda's caseworker, lawyer, and Jean Conroy continued to argue for a therapeutic foster care placement. All felt that if Amanda were placed in a psychiatric institution, she would never learn how to adjust to a normal family or how to be part of a normal community. They feared she would be in an institution for the rest of her life.

Janet Means testified that she agreed with the Northmont staff's conclusion that Amanda needed more intensive treatment, but she argued that intensive treatment did not necessarily demand greater restrictiveness. Judge Wilson was impressed and reassured by data Janet had gathered on the severe problems of children served by Home Works, but he had two major areas of concern. The first was the question of Amanda's schooling. He needed to know what arrangements would be made for Amanda's education. Janet was prepared for the question. Home Works was part of a larger agency that ran a day treatment and special education program in addition to therapeutic foster care programs. Amanda would attend school there.

Judge Wilson's second question concerned Janet's ability to find treatment parents who were not only willing but capable of taking on Amanda Shaw. From the judge's chambers Janet telephoned the most committed treatment parents in the program, Leslie and Dan Wagoner. Judge Wilson listened on the conference call as Janet reviewed Amanda's severe behavior problems with Leslie. Although he knew Janet had discussed the case with the Wagoners, Judge Wilson wanted to be sure Leslie knew the severity of Amanda's problems. Janet then asked Leslie if she and Dan had decided to take Amanda. Judge Wilson heard the confident, unequivocal, "Yes." Leslie and Dan Wagoner had already met Amanda for a preplacement visit, had reviewed her records, and had discussed at great length problems and possible treatment plans with Janet Means. Janet felt they were an excellent match for Amanda -- especially since the Wagoners were also Home Works parents to Amanda's younger sister, Carrie.

Judge Wilson had one last question. He asked Leslie for an unprecedented commitment. He wanted Leslie and Dan to agree to keep Amanda until an adoptive home could be found, even if that process took years. Leslie told Judge Wilson that she and her husband had made that commitment to all of their Home Works youngsters. If it took two years, or six years, or a lifetime, the Wagoners would never give up on a child who needed them.

Before making his decision, Judge Wilson questioned one final witness. He called Amanda Shaw into his chambers. They talked for a while and then he asked her if she knew the Wagoners. Amanda looked at Leslie and Dan and answered yes. When he asked the 10-year old if she wanted to live with them and be part of their family, Amanda asked eagerly, "When can I go?"

Janet Means was filled with anxiety as she rode with the Wagoners and their Parent Supervisor to pick up Amanda from Northmont. But Leslie and Dan chatted excitedly about the plans for their new child. As she listened to their enthusiastic voices, Janet's thoughts turned to June of 1982, the summer when the Wagoners began their preservice training. Janet had been the trainer and remembered clearly the first preservice session. Leslie and Dan arrived early and took two seats in the front row. They were pleasant and courteous, but they seemed nervous and were quite business-like. Janet introduced the Home Works program and parent responsibilities, along with the history and philosophy of therapeutic foster care. Then she paused briefly. From behind the podium, Janet made eye contact for a few seconds with each person. "You tell me you want to help a troubled child? That's very noble." Moving away from the podium and standing directly in front of a trainee, she asked threateningly, "But what would you do if your troubled kid urinated all over the sofa and rug in your living room -- on purpose?" Not waiting for a response from the shocked student, she moved on to the next trainee and offered another challenge. Janet continued until she had confronted each person in the class with an unnerving hypothetical situation. She talked about sleepless nights and calls from angry neighbors and teachers, as well as visits from the police.

Janet then distributed the thick trainee manuals and explained that treatment parents needed to be highly skilled teachers to counteract the negative behaviors youngsters had taken years to learn. She assigned reading material and explained the written work that was due the following week. She stressed the importance of coming fully prepared and on time. If prospective treatment parents did not have the interest or time to complete homework assignments, they most assuredly did not have the commitment and time they needed to implement the intensive treatment program and provide the supervision a troubled youngster would require. By the end of that session, two couples had decided they were not meant to be treatment parents. The others would be back. Eight of the original trainees were certified that summer. The Wagoners were the first to have a child placed in their home.

By the time their van reached Northmont, Janet's anxiety about placing Amanda with Leslie and Dan had diminished. Not only had the Wagoners been exceptional students in the training, never missing a session and always coming prepared, they had done an excellent job with their first three Home Works' youngsters. Their first son had joined the Marines, and he wrote to his "parents" regularly. Their second son had successfully graduated from the program, was living with a foster family and attending a public school. And Carrie Shaw was doing well. Amanda would be the biggest challenge they had experienced, but Janet knew they were well-prepared and ready to begin. She began to mentally select a team of experts to assist them.

Janet knew that Parent Supervisor Jon Daniels possessed the necessary qualifications not only to help design and implement Amanda's treatment program, but also to supervise and counsel the Wagoners. In his three years with the Home Works program, Jon had demonstrated the personal qualities it took to be a Parent Supervisor. He was patient, but determined. He had shown flexibility and creativity in designing successful interventions for unique individual problems. Jon was willing to stretch the limits of therapeutic foster care for a youngster, but he never went beyond the philosophy of the model. To Jon, each new youngster was a personal challenge, a test of his knowledge and his ingenuity. He also was well aware that he could not do the job alone. As a leader and teacher, Jon inspired his level of commitment in his treatment parents.

Jon's experience prior to his job with Home Works would also be valuable in his work with Amanda. Before becoming a Parent Supervisor, Jon was employed as a caseworker by the county. He was diligent in his work for children and teenagers who had fallen into the system. He was also frustrated by a caseload that included 40 youngsters. With a large caseload and its requisite paperwork, Jon was unable to spend even an hour a week with each child. He had read about an opening for the position of Parent Supervisor with the Home Works program. The salary was lower than that paid by the county, but he would be required to manage a caseload of only six youngsters. A master's degree in psychology, social work, counseling, education or other child mental health field was preferred, but his bachelor's degree in psychology, along with his experience as a caseworker, made him a qualified applicant.

In 1983, Jon interviewed with Janet Means for the job. He was unimpressed by the salary but extremely impressed by Janet and the other staff members he met. He was also inspired by the fact that through Home Works he could have a direct impact on the lives of children and teens. Unlike his job as a caseworker where he worked only with foster parents and on case records, the Parent Supervisor worked in every area necessary for the child's benefit. In essence, he would follow a child from the beginning through to the successful completion of the program. Then he would follow up on the progress of the graduate.

As a Parent Supervisor, Jon's responsibilities would include training prospective treatment parents, developing treatment plans, and supervising certified treatment parents as they implemented those plans. He would assume the roles of teacher and counselor. For the six youngsters in his caseload, he would also be an advocate in their schools, communities, and in the court system. If a youngster would benefit from attending a summer YMCA camp, he would insure that the resources were available to make that experience possible. Not a member of a sedentary type of profession, Jon would be called upon to chase and retrieve runaways, and he would go to court to fight for their most appropriate placements and their best chance.

Working with each child's biological family to improve the youngster's chance of returning home was also of great interest to Jon. Through Home Works he could run parenting groups for the children's own families and in this way help adults who had made a commitment to change their lives.

The job description for Parent Supervisor covered three full pages. It described a demanding job that would most likely require a 60-hour work week. As Jon became more intrigued by the work, his concern about salary slipped several points on his mental list of priorities. His paycheck would pay his rent, but his reward would come when he could look at a child and say, "I've saved his life!" Jon epitomized the zealot that the Home Works program needed.

Janet Means was impressed by Jon Daniels' idealism as well as by his credentials. Jon's work was significant to him personally, but he also believed in the global significance of helping one child. At the end of their first interview session, Janet offered Jon the job. Jon accepted without hesitation. This would not be the job that would allow him to trade in his dilapidated yellow Pinto on a newer model car; nor would he replace the second-hand couch that had been in his apartment since college. It would, however, be the job through which he would realize a dream.

Jon brought with him to his job with Home Works an experience that would be invaluable in Amanda's case. Several years earlier among the 40 youngsters in his caseload for the county was an extremely troubled six-year old. Her foster placement had failed because of her severe behavior problems. Her future was uncertain. Now, as a Parent Supervisor for Home Works, Jon was to meet the youngster once again. This time Jon Daniels was determined that Amanda Shaw would not fail.

Jon and Janet proceeded in their preparation for a new child. Their program's psychiatrist and psychologist interviewed and evaluated Amanda. In order to gain a clearer understanding of Amanda's problems, Janet and Jon interviewed the staff of the residential program where Amanda had lived for a year. They then met with the Wagoners, the psychiatrist, and the psychologist, to begin to develop an individual treatment plan and to define Amanda's behavioral objectives.

The list of behavioral objectives for Amanda was extensive. Basically, she would need to be retrained in many behavioral areas. She would work on developing appropriate table manners, practicing personal hygiene, telling the truth, respecting her own and others' property, accepting limits and consequences set by her parents, taking correction appropriately, and following directions immediately without arguing, complaining or pouting. And that was only a small part of the list. Each of these behavioral objectives addressed problems common to many emotionally disturbed youngsters. What was unusual was the fact that Amanda needed training in so many different areas. The child who moved into the Wagoner's home was a terribly troubled and difficult youngster, but she did not live up to her violent, dangerously aggressive reputation. Far beyond the initial two weeks, which staff referred to as the "honeymoon period," Amanda was still relatively nonviolent and nonaggressive towards her family. An antique mirror, a clock radio, a chair, a window and several dishes were the only victims of Amanda's rage.

Amanda worked hard at pleasing her new parents. More than anything she wanted to live in this home with its swimming pool and big yard, her own room, a brother and sisters, and a dog and cat. She wanted to be part of this happy, loving family. Leslie, who was the primary treatment parent, worked to exhaustion each day implementing Amanda's treatment plan, adjusting goals or interventions, and recording the results. Jon Daniels would come twice a week, or whenever Leslie needed him, to counsel Amanda or help solve a problem. They found that the family's swimming pool served as a powerful reinforcer during the summer months and put it to good use in strengthening desirable behavior or weakening an undesirable behavior.

On a sunny, warm day if Amanda was following directions well, she would earn points toward a swim in the pool at a designated time of the day. Leslie kept track of Amanda's points on a large chart taped to the refrigerator. Amanda could see the connection between her behavior and the rewards or consequences.

Every minute of her day Leslie kept close track of what Amanda did, taught her various skills, praised her, gave or took away privileges, and simply spent time interacting with her. It was a full-time, often exhausting job. Even at night when the children were in bed, Leslie's work would not be over. Completing the "Log of Daily Events" was interrupted by calming Amanda after a nightmare or changing the sheets after she had wet the bed.

Amanda attended the Belleview Day School, a day treatment and special education program for emotionally disturbed children that was part of the larger agency which included the Home Works program. The school staff were willing to accept Amanda in spite of her erratic behavior for the same reason that Home Works took her -- no one else would, and Amanda deserved a chance.

On her first day of school, Leslie Wagoner realized how difficult school would be for Amanda. When the cab driver arrived at school, he told the teachers he would never transport Amanda again. Her behavior endangered him and the other children. In the classroom she was out of control and was physically restrained from hurting herself or others as often as 10 times a day. Over the first few weeks, Leslie and Jon Daniels worked closely with the special education teachers and family liaison specialist to combat Amanda's aggression at school. But the interventions were insufficient.

After a particularly aggressive outburst, the family liaison specialist called Leslie and asked her to come to the school. When Leslie entered the classroom, two desks were overturned and a bookcase was on the floor in the corner. Papers and books were everywhere, and two teachers were holding Amanda down on the floor. One teacher was trying to calm Amanda while the other was teaching a social studies lesson to nine other students who were taking notes and answering questions.

When Amanda saw her "mom," she calmed down immediately. The teachers and Leslie decided to make use of that fact. For the next several days Leslie sat in the back of the classroom. Amanda's behavior improved significantly. To fade her involvement, Leslie then began sitting in the office and would only intervene when Amanda's behavior problems escalated. Some days Leslie would only stay for an hour. After several weeks, Amanda did not know if her mom was at school or not.

The intervention was effective, but Leslie was tired. Not only did she have her own treatment system to work on with Amanda, she also began consequating Amanda's school behaviors, positive and negative, at home. Although everyone was frustrated and exhausted, no one was willing to give up on Amanda. Given the opportunity of sending Amanda to another classroom, the teachers asked for more help instead. Leslie and Dan saw many positive signs at home, and the teachers were beginning to see minor improvements.

Then Dan Wagoner was called out of town for an extended business trip. He would be away for two months. Despite Leslie's explanations, Amanda believed that her family was falling apart once again and reverted to violent and aggressive behavior at home as well as at school. With her husband away, Leslie needed help. She accepted Home Works' offer to place a full-time aide in her home. She also requested respite care, having Amanda stay with another treatment family on weekends. Amanda's treatment team met to discuss interventions, but Leslie was exhausted. For the first time in her life she wanted to give up on a child, and she hated the feeling.

Meanwhile, Mattie Shaw was released from prison after two years. She was alone. Her husband was serving a 20-year sentence for abuse and neglect. Their children, Amanda and Carrie, were living in a Home Works home. Mattie had no family, few friends and no job, but Mattie had a goal. She was going to get her kids back.

In Mattie's mind her verdict of guilty on several counts of neglect and endangerment had been unjust. Why had the judge not understood that the drugs and alcohol had left her confused, had caused her to "black out?" She told Judge Wilson she did not know that her husband was beating the kids or sexually abusing them. If what they said was true, that she beat the girls or watched as neighbors forced them into oral sex, she was not responsible. But the verdict had been "guilty." Now things were different, she thought. She had served her sentence and was free from drugs for the first time since she was 15 years old. Mattie felt she could see things clearly. She would get a job and an apartment. She would get her kids back.

Home Works Parent Supervisor Jon Daniels was surprised and unsettled when Mattie Shaw called. She wanted him to arrange for Amanda and Carrie's return. Jon explained that the courts had terminated her parental rights. He could not reverse that decision. Mattie was angry, screaming into the phone that Amanda and Carrie were her kids and no one could keep her from them.

Jon discussed the phone conversation with Janet Means and with members of the staff. Amanda had begun to show signs of improvement in Leslie and Dan Wagoner's care. But her gains at this point were fragile. Re-introducing Mattie Shaw into her daughter's life might result in a serious regression for Amanda. In the past, Amanda's behavior would become violently aggressive after a visit with her mother. They had always had a poor relationship. Even if Mattie had changed, it would take many years before Amanda would be healthy enough to confront the issues surrounding her mother. The Home Works staff felt that they could not allow Mattie Shaw to become involved in Amanda's life yet, particularly in view of the court's termination of parental rights. However, the staff felt that even though Mattie had no parental rights, she had made obvious changes in her life and deserved help and support to continue. They agreed that Mattie might benefit from the regularly scheduled support meetings for parents of children in the Home Works program.

Jon telephoned Mattie, told her the date of the next parent meeting and told her about the ground rules. She must not come intoxicated, she must be respectful of others in the group, she must agree to maintain confidentiality, and she would be expected to participate. Jon also invited Mattie to the parent dinner always held before the meeting. She would be there if Home Works provided the taxi fare.

The dinner hour had become an important part of the meeting. Spontaneously, the parents would help in setting up the tables and serving the food, the whole time talking and sharing problems or achievements with one another. Jon often found dinner time to be the most productive part of the meeting.

According to their self-designed agenda, the group spent the first half of each session discussing individual goals and setting new goals for the following week. Albert Whitehead, a 17-month veteran of the parent group, spoke up first. Dressed in a well-worn but neat suit and a brightly patterned tie,. he sat with his briefcase on his knees. On top of the briefcase was his daily calendar. His goal for this week had been to arrange for two job interviews. He proudly announced he had not only accomplished his goal but had secured a promising second interview with one of the companies. His friends applauded the achievement, but only Jon Daniels knew what an amazing accomplishment this represented for Albert. He remembered the first night Albert came to the parents' group. He was intoxicated and was chain-smoking. He obviously had not bathed or changed his clothes for several days. His eyes were glazed and his speech garbled. He was not an angry or violent man and seemed to love his daughter, but he lacked parenting and social skills. His 15-year old was out of his control, unmanageable at school and developing a pattern of truancy. He was incapable of providing for her, and she had been placed in the Home Works program.

Jon remembered Albert's first goal. He was to drink no alcohol the day of the meeting -- another "small step" goal. An incentive was that he could visit with his 15-year old daughter before the meeting if he were sober. With phone calls and visits from the Home Works Parent Supervisor during the week, Albert managed to achieve this goal. That night he had a positive visit with his daughter, a hearty meal and a productive meeting. Albert felt a sense of accomplishment. His next goal would be to attend the meeting sober and clean. It would be the first step in improving his self-image. For the first time in his adult life, Albert had found a support group, friends who not only wanted to see him succeed but who would help him in his efforts. It had been a long process, with frequent set-backs and frustrations, but Albert announced that if he got this job, he could rent the "two-bedroom apartment in a better neighborhood" that his Parent Supervisor helped him find, and Julie would be moving in with him soon. He was overjoyed.

His success had produced a sense of hopefulness in the group and the discussion continued with energy. After each member of the group discussed individual goals, Jon asked Mattie if she wanted to talk about a personal goal for the following week. Without looking up she told Jon quietly that she was going to get her kids back. It was her only goal. None of this was her fault. She did not need to play these games. Two years in prison was payment enough, especially since she was wrongly accused.

Albert was the one to respond. He spoke to Mattie with directness but also with understanding. He said he used to blame everyone else for his problems. It was his factory's fault for laying him off or his wife's fault for abandoning him and their child or welfare's fault for not providing enough money. Sure, life had dealt Albert some tough blows, but he said that when he was accepting absolutely no responsibility, nothing changed, his life only got worse.

Mattie was surprised. She said she expected support from these people, not a sermon. Angered, she slammed the door as she left the meeting. Albert knew she would return, because she had expressed an important goal. She was determined to get her kids back. But Jon Daniels wondered if the courts would hear her appeal, if the judge would feel she deserved another chance In any event, he hoped the appeal process would not begin soon.

Amanda needed a lot of time and a great deal of support before she could face another judicial review and another change in her life.

When Home Works held a staffing on Amanda, an exasperated Leslie Wagoner described her feelings to the treatment team. "Living with Amanda is like living with a time bomb." Having spent most of the previous night at the emergency room, watching a doctor remove wads of construction paper from her foster daughter's ears, Leslie was exhausted and beginning to believe that she had failed. She had agreed to meet with the professionals from Home Works not to discuss yet another treatment plan, but to plan for Amanda's move to another family.

A seasoned professional, Leslie had been meeting the challenge of treatment parenting Amanda and her younger sister, Carrie. Leslie had also felt that her own two children were progressing well in a difficult situation. But when Dan was called away and Amanda's behavior moved from difficult to unmanageable, Leslie's own children began acting out. Leslie's confidence in her treatment parenting ability was rapidly diminishing.

But Janet Means, Jon Daniels, and psychologist, Dr. Steven Ashe, still believed the Wagoners were the best treatment parents for Amanda. They were a remarkable couple with a tremendous commitment to difficult children. Staff felt that with constant support over the next four weeks until Dan returned, Leslie would be able to implement the intensive treatment program planned for Amanda.

Leslie needed encouragement, and the staff's heart-felt pep talk helped. They promised respite care at any time and continuation of a full-time aide. Janet and Jon also offered a new incentive. Each would stay with Leslie's four children for a weekend, allowing Leslie time alone to visit her husband.

Reluctantly, Leslie agreed to keep trying. They discussed the new motivation system. It was based on Amanda's need for an immediate negative consequence to occur when Amanda was involved in undesirable behavior. At the same time she needed an immediate positive event to occur when she was involved in a desirable behavior. The key word was "immediate." Developmentally, Amanda was functioning at the level of a three-year-old, and so it was difficult, if not impossible, for her to make the connection between some misbehavior at 8:00 a.m. and the bedtime story she would miss at 8:00 p.m. as a consequence of that misbehavior. Most importantly, the team stressed the need for accurate documentation for evaluation purposes. A long-term view of whether Amanda was really progressing or not would be critical.

Leslie was also involved in teaching Amanda to tell the truth. Several times a day Leslie would ask Amanda a question, such as, "What did you eat for breakfast this morning?" They were "truth-probes," questions to which Leslie knew the answer. A response of "bacon and eggs" on a morning when Amanda had eaten cereal would cost her a token. And Leslie would explain truth and untruth to the now 11-year-old who had never learned the difference.

In addition to implementing the motivation system, which consisted of a clear tube with chips consistently added and subtracted to indicate what Amanda did and what she could earn, Leslie would be providing continual praise -- descriptive, instructive praise. "I like it when you help me by carefully putting the clean dishes away," was not only reinforcing, but it also included a "how to" lesson. Leslie began to wear a golf counter on her wrist so she could record each time she praised Amanda's behavior. Leslie's almost minute by minute documentation of all of these interventions in her Log of Daily Events was time consuming, but it was providing important data through which staff could evaluate Amanda's progress.

By the time Dan Wagoner returned home, Leslie was implementing the new treatment plan consistently and with confidence. She celebrated her husband's return, looking forward to the support of her partner. But for Amanda, Dan's arrival represented another transition. On his first night home, Dan witnessed the kind of tantrum that Leslie had tried to describe to her husband. Amanda had opened Dan's briefcase, and when he asked her to close it, she refused, scattering the papers on the floor. When he directed her to pick up the papers, Amanda threw the briefcase, smashing a lamp. When she began throwing the pieces of lamp at her family, Dan restrained her. Screaming obscenities, biting, kicking, and scratching, Amanda was out of control. Leslie helped hold Amanda down, and as she did, she repeated calmly, "It's O.K. I'm Leslie, your mom, and you're Amanda, and you're in your home safe with us." Finally Amanda seemed to hear Leslie, and she cried out, "Wake me up please, mommy, I'm having a bad dream."

Dan Wagoner was shocked by the violence of Amanda's attack. Blood was dripping from his hand and his shirt was ripped. That night after Leslie painstakingly recorded the events of the day, Leslie and Dan talked. It appeared to Dan that Amanda had made no progress at all. But Leslie, in consultation with Dr. Ashe, Jon and the rest of the team, had adopted a new way of assessing the efficacy of their efforts. She explained that Amanda's behavioral progress could only be judged by evaluating the data as a whole. Leslie had learned not to be too pessimistic about a day when Amanda was on task for five-minute intervals only 10 percent of the time, because that day might be followed by one in which Amanda was on task 85 percent of the time. Looking at graphs of Amanda's behavior was like following a bouncing ball, but the overall picture suggested progress.

Without the careful documentation that Leslie and Amanda's teachers provided, a pattern of improvement would be unobservable. It was not the behaviors themselves, but rather the pattern that offered encouragement to Leslie. But Leslie was inspired by something new. Earlier that night, when Amanda had been out of control and had cried for help to wake up, Leslie felt for the first time that she had reached deep into Amanda's heart and found an even more important reason to continue. Amanda was living a nightmare. Leslie wanted to awaken this child to a better life.

Two years after Amanda's entry into Home Works, many visitors remark on the two photographs hanging on the bulletin board in Jon Daniels' office. One shows a 10-year-old girl who is standing alone, staring into the lens with a wild, wide-eyed expression. Her hair is unkempt, the result of her own snipping. Her clothes are mismatched and disheveled, her cardigan sweater buttoned unevenly. In the background children are playing.

Having just returned from a counseling session with Amanda in her therapeutic foster home, Jon Daniels has a hard time believing this photograph is actually Amanda Shaw, even though he himself had taken the picture when she first moved into Leslie and Dan Wagoner's home. During his home visit that day, the 12-year-old Amanda's pretty hazel eyes were shining above a bright smile. She was wearing a pink and white-striped blouse with a denim skirt. Amanda's wavy blonde shoulder length hair was pulled back neatly on each side by a ribbon-covered barrette. She clutched a package in her hands, a present for her "best friend's" birthday party.

Looking at the photograph, Jon realizes the tremendous amount of work as well as the success Amanda represents. But the changes that have occurred in Amanda go far beyond stylish clothing and a neat appearance. Lately, her treatment parents, Leslie and Dan, rarely record restraints or even occasions of physical aggression from Amanda. She follows directions and is learning not to lie. She is learning to get along with her peers, is participating in more group activities, and is learning, sometimes painfully, what it means to have friends. As Amanda's behavior improves her teachers are finally beginning to see academic progress. Yet, as recently as six months ago, Leslie was still documenting Amanda's defiant, aggressive behavior. The Wagoners know that the potential exists for Amanda to return to her destructive ways, but as the days go by they also know she is learning a more powerful lesson in acceptable alternatives.

There remains much to be done for Amanda, and no one is breathing easily. There is still the question of Amanda's own mom wanting her children back. Mattie Shaw is still fighting for custody of her daughters. But Leslie and Dan are ready to adopt Amanda and Carrie Shaw. It will be a long process before the final decision can be made by the courts.

At the age of 11 after many months of counseling, Amanda finally began to disclose fragments of her nightmarish past. She revealed that her father's beatings with the paddle were much harder than her mother's. In a counseling session, when given doll furniture, she had described everything as "Daddy's," the chair, the bed, the refrigerator, the car, the pets. Daddy owned it all. She would quickly slip into fantasy when given dolls, ripping the clothing from the little girl dolls. One day she cut the hair of the adult male doll, "So he be bald like daddy." She would lay the male doll on top of the other, obviously in a position of fellatio. When asked once to name the male doll she responded, "That's the big man who took his pants down." At the close of the session she would kiss the dolls good-bye and smile happily, saying to the girl doll, "You're a nice lady."

Even though these sessions had left Amanda aggressive and often violent, staff had encouraged Leslie and Dan to support the counseling because they believed it to be a critical part of Amanda's treatment. The Wagoners have also become a part of counseling around the subject of sexual abuse. They are teaching her the difference between appropriate and inappropriate language and touching. They are teaching her that she can and must say no. It will be, perhaps, the most difficult lesson of all.

Amanda is finally beginning to see her own worth as a person. To her treatment parents, her teachers and the Home Works' staff members, the pride Amanda takes in her accomplishments is actually more exciting than the accomplishments themselves. As Jon writes the report on his session with Amanda, the telephone rings. A friend is calling about David, a 13-year-old boy in his caseload whom no one else will take. He was burned in a fire at the age of two and remains terribly disfigured . . . horribly abused . . . retarded . . . noncommunicative .... As Jon listens to his friend he looks at the second photograph on his bulletin board. It is a picture of Amanda Shaw taken two weeks ago. Teachers had encouraged Amanda to join the school's track team and train for the 100-meter relay in the Summer Games of the Special Olympics. She agreed and worked hard, enjoying the feeling of being part of a team. In the corner of the photograph Leslie and Dan Wagoner are hugging one another. In the center is Amanda, smiling proudly, holding high her prize -- the gold medal. As Jon looks at Amanda's hopeful face in the photograph, he answers his friend, "Let's give it a try."

APPENDIX B

LIST OF PROGRAMS RESPONDING TO SURVEY

Appalachian Mental Health Center
Family Services Network
P.O. Box 215
Beverly, West Virginia 26253
(304) 636-7020

Baltimore Family Life Center
Extended Family Project
101 W. Read Street
Baltimore, Maryland 21201
(301) 837-5755

Beech Brook Staff Homes
Specialized Foster Home Program
3737 Lander Road
Cleveland, Ohio 44124
(216) 831-2255

Bringing It All Back
Home Study Center
Appalachian State University
Professional Parenting
204 Avery Avenue
Morganton, North Carolina 28655
(704) 433-6812/7176

Catholic Charities, Inc.
Therapeutic Foster Care
P.O. Box 2248
Jackson, Mississippi 39205
(601) 355-8634

Children's Aid & Adoption Society
Treatment Home Program
360 Larch Avenue
Bogota, New Jersey 07603
(201) 487-2022

Children's Center of Wayne County
Therapeutic Foster Care
101 Alexandrine East
Detroit, Michigan 48201
(313) 831-5535

Children's Service Center of Wyoming Valley
Parent Counselor Program
335 South Franklin Street
Wilkes-Barre, Pennsylvania 18702
(717) 825-6425

CPC Mental Health Services, Inc.
Therapeutic Community Homes
59 Broad Street
Eatontown, New Jersey 07724
(201) 842-2000

Daniel Memorial
Career Parents Program
3725 Belfort Road
Jacksonville, Florida 32216
(904) 737-1677

Diversified Human Services
Host Family Residential Program
Eastgate 8
Monessen, Pennsylvania 15062
(412) 684-9000

East Arkansas Regional Mental Health Center
Therapeutic Foster Care
305 Valley Drive
Helena, Arkansas 72342
(501) 338-6741

Family Alternatives
416 E. Hennepin
Suite 218
Minneapolis, Minnesota 55414
(612) 379-5341

Family & Children's Services
of the Kalamazoo Area
Treatment Foster Care
1608 Lake Street
Kalamazoo, Michigan 49001
(616) 344-0202

Human Service Associates, Inc.
333 Sibley Street, Suite 770
St. Paul, Minnesota 55101
(612) 224-8967

Huron Services for Youth
1952 S. Industrial Highway
Ann Arbor, Michigan 48104
(313) 994-4224

Kaleidoscope, Inc.
Therapeutic Foster Family Programs
1279 N. Milwaukee
Chicago, Illinois 60622
(312) 278-7200

Lee Mental Health Center
Family Network Program
P.O. Box 06137
Ft. Myers, Florida 33906
(813) 275-3222

Lutheran Social Service of Iowa
Foster Care
3116 University Avenue
Des Moines, Iowa 50311
(515) 277-4476

Northeast Mental Health Center
Specialized Foster Care
5515 Shelby Oaks Drive
Memphis, Tennessee 38134
(901) 382-3880

Northeastern Family Institute
Professional Foster Care
431 Pine Street - Maltex Building
Burlington, Vermont 05401
(802) 658-2441

Professional Association of Treatment Homes
(PATH)
1730 Clifton Place
Minneapolis, Minnesota 55403
(612) 871-4314

People Places
1215 N. Augusta Street
Staunton, Virginia 24401
(703) 885-8841

PRYDE Pressley Ridge Youth
Development Extension
Pressley Ridge School
530 Marshall Avenue
Pittsburgh, Pennsylvania 15214
(412) 321-6995

Rainbow Mental Health Facility
Partners in Parenting
2205 W. 36th Street
Kansas City, Kansas 66103
(913) 384-1880

Starr Commonwealth Schools
Hannah Neil Center for Children
Specialized Foster Care
301 Obetz Road
Columbus, Ohio 43207
(614) 497-0122

Transitional Residence Independence
Service (TRIS), Inc.
Specialized Foster Care
1 Colby Avenue
Stratford, New Jersey 08084
(609) 346-1800

Tri-County Youth Services
Nexus Foster Care & Alternative Living
for Youth (ALY)
16 Armory Street
Northampton, Massachusetts 01060
(413) 586-6210

Ventura County Children's Mental Health
Demonstration Project
Shomair Enriched Foster Care Program
300 Hillmont Avenue
Ventura, California 93003
(805) 652-6737

Wake County Juvenile Treatment System
One on One Program
2321 Crabtree Boulevard
Raleigh, North Carolina 27604
(919) 755-6800

West Virginia Youth Advocate Program
P.O. Box 295
Wheeling, West Virginia 26003
(304) 232-5088

Youth Alternatives of Southern Maine, Inc.
Family Services
175 Lancaster Street
Portland, Maine 04101
(207) 874-1175